Mozambique

Country Operational Plan

(COP) 2016

Strategic Direction Summary

April 19, 2016

Contents

GOAL STATEMENT

The United States Government (USG) government goal for the President's Emergency Plan for AIDS Relief (PEPFAR) in Mozambique is to achieve control of the Human immunodeficiency virus (HIV) epidemic through the rapid adoption and application of the most proven policies and interventions to drive progress and save lives, based on the best science, the most rigorous use of scientific information, and a partnership between our two governments that best supports host country leadership, ownership and sustainability.

PEPFAR will achieve this goal by supporting the National AIDS Program with government, civil society and other stakeholders such as the Global to fight AIDS, Tuberculosis and Malaria (GFTAM) and the private sector to target evidence-based interventions for populations at greatest risk in areas of greatest HIV incidence.

This support is focused on providing the technical assistance, training and mentoring available, coupled with requisite medicines, test kits and other health supplies to ensure the National HIV Program can test, treat and suppress the viral load in Mozambicans living with HIV, and prevent Mozambicans from contracting the virus, to effectively achieve an AIDS-Free generation by 2030. This Strategic Direction Summary details the objectives and activities for the US$389 million budget apportioned to PEPFAR-Mozambique.

In the past four months, two events substantially altered the landscape of the partnership between the USG and the Government of the Republic of Mozambique (GRM). After much negotiation, the two governments signed a bilateral agreement in December 2015 which reopened the possibility of direct government to government (G2G) support of Mozambique's HIV/AIDS response. Then in March 2016, following on the strategic visit of Ambassador Deborah Birx (PEPFAR), Ambassador Mark Dybul (GFTAM), and UNAIDS Executive Director Dr. Michel Sidibé (UNAIDS) to underscore the urgency of adopting the new Test and Start (T&S) World Health Organization (WHO) treatment guidelines, the Mozambican Ministry of Health (*Ministério da Saúde* -MISAU) announced adoption of a new treatment threshold (ART at CD4>500), and phased implementation of T&S to begin in 2016. By the end of this Country Operational Plan 2016 (COP16), Mozambique's phased implementation will cover 60% of all People Living with HIV (PLHIV), and in COP17, all PLHIV in Mozambique will have early access to life-saving treatment.

PEPFAR-Mozambique will support the GRM to achieve ambitious targets to increase the number of adults on anti-retroviral treatment (ART) from 738,386 (end December 2015) to 909,281 adults and 83,860 children by October 2017. To reach these targets for treatment, 5,332,066 people will be tested for HIV using those modalities that have been most successful at finding HIV-positive people. Male circumcision, a critical prevention measure, will be scaled to reach 258,174 men. Adolescent girls and young women (AGYW) living in the five highest burden districts of Mozambique will benefit from the concentrated support of the **D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored and **S**afe (DREAMS) initiative to help protect them and their male partners from acquiring or spreading HIV. PEPFAR will also continue to support Orphans and Vulnerable Children (OVC), and to target services to some of the most vulnerable key and priority populations, recognizing that to support these populations means continuous advocacy for human rights and an end to gender-based violence (GBV).

PEPFAR-Mozambique activities will continue to follow the geographic prioritization and differentiated support models approved in COP15, with slight adjustments such as clustering of urban/peri-urban areas to maximize investments and assure continued progress toward epidemic control.

COP16 represents a calculated risk in investments by PEPFAR, particularly for commodities that are needed to implement T&S. The team is confident that this plan includes the necessary budget to assure commodities for the anticipated increase of people on treatment. PEPFAR-Mozambique also took a critical look at the systems investments it has been making in Mozambique to ensure that there is no duplication with other stakeholders, and that the investments are strategic for T&S implementation. Supply chain, human resources, and strategic information support are the critical systems that will be supported in this plan, with laboratory support woven throughout.

The main challenges to epidemic control are to find HIV positive people (first 90), to start them on treatment, and to keep them on treatment. Mozambique has relatively lower retention rates than neighboring countries, with pregnant women and children having the lowest retention rates. MISAU is introducing innovative changes to the service delivery model to help keep more Mozambicans healthy and virally suppressed. The impact of these changes will be monitored at each phase of the national introduction of T&S, to help assure that lessons learned are broadly applied, and that Mozambique gets to epidemic control.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country profile

Mozambique is a predominantly rural country of approximately 26 million people challenged by a severe generalized HIV epidemic. National HIV prevalence is 11.5%, with substantial variation in regional prevalence ranging from 25.1% in Southern provinces to 3.7% in Northern provinces. In 2015, there were an estimated 25,727,911 [1] PLHIV, with a higher prevalence among women (13.1% vs 9.2% in men) and especially among young women (aged 15-24 years). AGYW are particularly at risk in Sofala and Gaza provinces, where they are disproportionately affected at rates five and six times higher in comparison to men (Fig 1.1.1). Prevalence among adolescent girls is estimated at 11.1%.[2] Of the estimated number of PLHIV, 51% are currently on ART. The HIV epidemic has contributed to a low life expectancy of 51 years, and there are approximately 848,000 orphaned children.

Despite encouraging economic growth, estimated at over 7% over the last 3 years, the Human Development Index (HDI) ranks Mozambique 180 out of 187 countries.[3] Sixty percent of Mozambicans live on less than $1.25/day; gross national income is $600 per capita.[4] Key health indicators indicate gradual improvement in health status; however, challenges remain. Although antenatal coverage, defined as at least 1 visit, is 91%, maternal mortality ratio remains high at 490/100,000 live births. Under-five child mortality is 90/1,000 live births, declining from 103/1,000 live births in 2010.[5] Malaria, diarrhea, acute respiratory infections, and vaccine-preventable diseases are the main causes of child

[1] EPP SPECTRUM Version 5.03.2014; 2015 estimate
[2] AIDS Indicator Survey INSIDA 2009
[3] Human Development Report 2015, UNDP
[4] World Bank 2014
[5] Mozambique DHS 2011& UNICEF 2012

death, with malaria contributing to one third of child mortality. Forty three percent of children under the age of 5 years are stunted.

The Gender Inequality Index reflects gender-based inequalities in three dimensions – reproductive health, empowerment, and economic activity - on which Mozambique ranks 135 of 155 countries. Mozambique has high rates of early marriage: 60% of women aged 25-49 were married before age 20. About 40% of Mozambican women become pregnant before the age of 20. The adolescent pregnancy rate is 137.8 births per 1000 live births, with the risk of death among pregnant teenagers four times higher than for women above the age of 20. One and a half percent of adult women have reached at least a secondary level of education compared to 6% of their male counterparts.[6]

Key drivers of Mozambique's HIV epidemic are low coverage of ART, risky sexual behaviors, low rates of male circumcision, low and inconsistent condom use, mobility and migration, and sex work. Qualitative studies highlight social and cultural factors that shape attitudes and behaviors towards risk, sexual relations, prevention, care seeking and use of services.

The 2009 AIDS Indicator survey (INSIDA) is the most current source of population level data about the epidemic.[7] INSIDA data show 433,000 HIV-sero-discordant couples, representing 10% of all cohabiting heterosexual couples. At least 58% of PLHIV did not know their HIV status. Condom use is limited but more common in urban populations. Among women age 15-49 that had sexual intercourse in the last 12 months, 8% reported the use of a condom during their last intercourse (19% urban, 3% rural). The proportion increases to 16% among men age 15-49 reporting the use of a condom during their last intercourse (33% urban, 7% rural). Male circumcision (MC) is common in the northern provinces of the country, where it is performed for traditional and religious reasons. Nationally, MC prevalence is reported at 51%, with geographic variations ranging from 2% (Central region) to 95% (Northern region).

A Modes of Transmission model conducted in 2013 shows 28.7% of new infections were among sex workers, their clients and men who have sex with men (MSM), and 25.6% of new infections occur among people in stable sexual relationships, due in large part to high rates of sero-discordance and low rates of condom use among couples. People in multiple partnerships contributed to 22.6% of new adult infections. Mobile and migrant workers such as miners, agricultural workers, prison populations, the military, and truck drivers also constitute priority populations.[8]

In comparison to many other African countries, Mozambique has relatively lower national retention rates of 66% at 12 months, and even lower in pregnant women (55%). Innovative efforts are being planned and implemented at both facility and community levels to retain and track people on treatment. Retention for pediatric PLHIV is lower than for the general PLHIV population (64% versus 66% in APR15), and pediatric retention in pre-ART is very low (the data are unreliable but are estimated at ~26% in 2015). The health sector struggles with limited funding and infrastructure and a

[6] Human Development Report 2014, UNDP
[7] A new survey is underway with final results expected in FY17
[8] Military – Seroprevalence and Behavioral Epidemiology Risk Survey in the Armed Forces of Mozambique 2010

critical shortage of human resources for health.[9] More than half of all Mozambicans walk over one hour to reach the nearest health facility. Overall the ratio of population per hospital bed is 1 bed per 1,038 persons, with great variation across the country.[10] Health facilities face a general dearth of basic amenities: 55% lack electricity and 41% lack running water. Human resources for health (HRH) are severely constrained with 6.5 doctors, 28 nurses, and a total of 66 health care workers (HCW) per 100,000 people (MISAU, 2012). The accepted standard is 230 medical professionals per 100,000 people (WHO, 2006). Together with uneven geographic distribution, there are an inadequate number of trained and competent HCW in all cadres and they often receive limited supervision.

The GRM's ability to oversee policies and regulations and coordinate health actors is challenged. Information systems and monitoring and evaluation (M&E) efforts are heavily supported by external funding and technical assistance and are not yet able to provide timely and accurate health data. The supply chain and commodities management is also fragile, and an area where PEPFAR provides substantial technical assistance. Development and capacity building of the National Health Information System and supply chain is a priority for COP16. The laboratory network to support HIV care and treatment also requires significant investment to expand the capacity of diagnostics services and strengthen currently fragile systems that make them accessible. Of the 1,438 health units in Mozambique only 344 have laboratories.

Despite these challenges and the heavy burden of the HIV/AIDS epidemic, there has been remarkable progress. Since 2011, the number of people on ART has increased nearly threefold, with an exponential increase since the launch of the National Acceleration plan (See Fig 4.1.2). With the rapid national expansion of health facilities offering ART from 255 in 2011 to 937 by the end of 2015, and with 202,672 adults newly initiated on ART in 2015 alone, by the end of December 2015 there were a reported 738,386 adults currently on ART.

There has also been remarkable progress in test and treat (B+ option) for pregnant women attending ANC, which increased from 12% of all PMTCT in 2012 to 91% in 2015. More HIV infected children are also being identified and started on ART with 18,115 initiating treatment in 2015 and a total of 64,273 children currently on treatment by the end of 2015. This number on ART represents 39% of all estimated PLHIV in the country.

In February 2016, MISAU announced its decision to adopt the revised WHO guidelines released September 30, 2015. Mozambique is now initiating ART for all patients at CD4 500, and will begin a phased rollout of T&S in August 2016, with T&S as the national norm by the end of 2017. To support these new treatment thresholds, Mozambique will move to 3-month scripting for stable ART patients, increased availability of viral load monitoring, and reduced frequency for clinical checkups to decongest health facilities. The National HIV Strategic Plan (*Plano Estratégico Nacional* de Resposta ao HIV e SIDA - PEN IV), which was developed with assistance from PEPFAR, is now being implemented and will be updated based on the revised national HIV treatment polices for the period 2017-2019.

9

[10] MISAU – DRH. Relatório Anual dos Recursos Humanos. Maputo, Abril 2014

With COP16, Mozambique will increase momentum towards achieving saturation of PLHIV on treatment, with 34 of 78 PEPFAR supported scale up districts targeted for 80% ART coverage of all PLHIV in the next 2 years. Based on these criteria, MISAU will exceed the targets laid out in the national Acceleration Plan.

Health and HIV Financing: The total budget allocated to health in 2014, the most recent year for which there is complete data, was US $635 million, representing 7.9% of the total national budget. PEPFAR funds are not included in this total. The share of internal to external resources increased from 45/55% in 2009 to 78/22% in 2014.

HIV expenditure in Mozambique reached US $353 million in 2014, representing a 65% increase from US $213.5 million reported in 2010. External budget support to the health sector from general budget support and health sector , PROSAUDE decreased, falling from 52% of the overall health budget in 2008 to 22% in 2014, due to increases in internal resources.[11]

Of the US $635 million national health budget in 2014, 48% was dedicated to the central ministry level, 15.7% to the provincial directorates (*Direcção Provincial de Saúde* - DPS), 16.5% to the district health, gender, children and social action (Serviços *Distritais de Saúde, Género, Criança e Acção Social* - SDSGCAS), 11.6% to central hospitals, 1% to the Central Medical Stores (*Central de Medicamentos e Artigos Médicos* - CMAM), and 1% to the National AIDS Council (*Conselho Nacional de Combate ao HIV e SIDA* - CNCS).[12]

Routine budget and expenditure data on investment of public resources in initiatives linked to specific diseases like HIV is difficult to measure. However, efforts are underway to begin program-based budgeting at the MISAU.

It is important to note that although over the past few years GRM has increased investment in the health sector in total dollar terms, the proportion of the total domestic budget allocated to health continues to fall well below the 15% commitment made in the Abuja Declaration. With significant increased state revenues from extractive industry gains expected within the next 15-20 years, GRM can prepare to increase its investments in and ownership of the health sector, including the fight against HIV/AIDS. It is important for the GRM, GFATM, and PEPFAR to work closely to create a clear and sustainable financing plan for anti-retroviral (ARV) drugs and other commodities, and execute timely disbursements to ensure the scale-up of treatment and improve systems to support over a million people on treatment by the end 2017. MISAU, with PEPFAR support, is completing a Health Financing Strategy and discussions are underway between MISAU and the Ministry of Finance (Ministério da Economia e Finanças - MINEF) regarding implementation of innovative financing mechanisms.

[11] UNAIDS GARPR 2014

[12] UNAIDS GARPR 2014

Standard Table 1.1.1

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	27,128,530	100	6,054,696	22.3%	6,019,972	22.2%	7,967,387	29.4%	7,086,475	*26.1%*	Census 2017
HIV Prevalence (%)		11.5%*		1.4%		1.6%		13.1%		9.2%	INSIDA 2009
AIDS Deaths per year	29,882		2,554		2,598		12,628		12,102		Spectrum projections, 2017 est**
# PLHIV	1,643,065		87,145		88,230		884,510		583,180		Spectrum projections, 2017 est**
Incidence Rate (Yr)*		South, 1.15 Center 0.40 North 0.48									Spectrum projections, 2017 est**
New Infections (Yr)	79,240										Spectrum projections, 2017 est**
Annual births	1,087,000										UNICEF, 2014
% of Pregnant Women with at least one ANC visit		90.60%									DHS 2011
Pregnant women needing ARVs	101,831										Spectrum projections, 2017 est**
Orphans (maternal, paternal, double) TOTAL ORPHANS (AIDS ORPHANS)	1,779,787 (532,612)										Spectrum projections, 2017 est**
Notified TB cases (Yr)	58,270										WHO Global TB Report, 2015
% of TB cases that are HIV infected	29,337	52%									WHO Global TB Report, 2015
% of Males Circumcised		48.40%									DHS 2011

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				*Source, Year*
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Estimated Population Size of MSM	Maputo City – 10,121 Beira – 2,624 Nampula/Nacala – 3,069										MSM IBBS 2011
MSM HIV Prevalence		Maputo City – 8.2% Beira – 9.1% Nampula/Nacala – 3.7%									MSM IBBS 2011
Estimated Population Size of FSW	Maputo City – 13,554 Beira – 6,802 Nampula – 6,929										FSW IBBS 2011-2
FSW HIV Prevalence		Maputo City – 31.2% Beira – 23.6% Nampula – 17.8%									FSW IBBS 2011-2
Estimated Population Size of PWID	Maputo City – 1,684*** Nampula – 520***										PWID IBBS 2013

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				*Source, Year*
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
PWID HIV Prevalence		Maputo City – 50.3%*** Nampula – 36.8%***									PWID IBBS 2013
Estimated Size of Priority Populations - Prisoners	N/A										
Priority Populations Prevalence - Prisoners		24.00%									INS & UNDOC Report 2013
Estimated Size of Priority Populations - Adolescent Girls****	2,764,226										Census 2017
Priority Populations Prevalence - Adolescent Girls****		11.10%									INSIDA 2009

**15-49 year olds*
***From Spectrum Files used for COP16 planning - MozREGIONmig2015.06.10 - CD4500 + TS, Version 5.31*
****Preliminary Data Not Yet Officially Released*
*****15-24 year olds*

Note: *Prevalence number for the military cannot be shared with the general public due to military concerns regarding HIV prevalence as it relates to national security. However, prevalence data and other military data were shared with the country team to inform COP15 decisions and inclusion of the military as a priority population.*

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence** (%)	**Total PLHIV** (#)	**On ART** (#)	**Retained on ART 12 Months** (#)	**Viral Suppression** 12 Months	**Tested for HIV** (#)	**Diagnosed HIV Positive** (#)	**Initiated on ART** (#)
Total population	27128530*	11.50%	1643065**	802659	528129	N/A	6630337	468870	*220787*
Population less than 15 years	12074668*	N/A	175,375**	64273	40865	N/A	N/A	N/A	*18115*
Pregnant Women	1087000*	15.20%	101,831**	99786	54882	N/A	1367536	77585	*62088*
MSM	Maputo City – 10,121 Beira – 2,624 Nampula/Nacala – 3,069	Maputo City – 8.2% Beira – 9.1% Nampula/Nacala – 3.7%	Maputo City - 830 Beira - 239 Nampula/Nacala - 114	Data Not Available					
FSW	Maputo City – 13,554 Beira – 6,802 Nampula – 6,929	Maputo City –31.2% Beira – 23.6% Nampula – 17.8%	Maputo City – 4,229 Beira – 1,605 Nampula – 1,232	Data Not Available					
PWID	Maputo City – 1,684*** Nampula – 520**	Maputo City – 50.3%*** Nampula –36.8%**	Maputo City - 847 Nampula - 191	Data Not Available					
Priority Pop Prisoners	N/A	24.00%	N/A	Data Not Available					
Priority Pop Adolescent Girls	2,764,226	11.10%	306,829						

** 2017 demographic projection estimate from Mozambique Census conducted in 2007*
*** 2017 estimate from Spectrum Files used for COP16 planning - MozREGIONmig2015.06.10 - CD4500 + TS, Version 5.31*
**** Preliminary Data Not Yet Officially Released*

***Note**: Prevalence number for the military cannot be shared with the general public due to military concerns regarding HIV prevalence as it relates to national security. However, prevalence data and other military data were shared with the country team to inform COP15 decisions and inclusion of the military as a priority population.*

1.2 Investment Profile

Overall expenditures for health and the allocation to HIV programs have increased in the last decade. The 2014 National AIDS Spending Assessment (NASA) reported HIV expenditures of US $213 million in CY10 (68% PEPFAR) and US $260 million in CY11 (72% PEPFAR). The UNAIDS Global AIDS Response Progress Report (GARPR) showed a 37% increase in HIV spending from 2012 to 2014 (US $256 million (75% PEPFAR financing), to (US $353 million (72% PEPFAR financing)

Donors finance the bulk of the HIV response. The GRM is the third largest individual source of funding, with US $21 million allocated to HIV and tuberculosis (TB) in 2013. Despite having doubled from 2004 to 2014, domestic public HIV expenditure represented only 3% of overall HIV expenditures in 2014.[22] it is estimated that 11% of MISAU recurrent expenses are allocated to HIV and TB. Other domestic spending from MISAU covers lab reagents and material and specific services (3% each in 2011). In addition to these allocations to MISAU, the GRM for HIV is also allocated to the CNCS for the coordination of the national response, and civil society organizations for community activities. Such activities totaled US $2.6 million in 2011.

HIV Expenditure by Programmatic Area. There is limited information on HIV expenditures by programmatic area. The most recent UNAIDS GARPR Report for CY 2014 (2015) showed 20% of HIV expenditures were used for prevention programs, while treatment and care accounted for 46%.

Expenditure towards Health System Strengthening. In 2013, US $292 million was invested in health systems (52% domestic public resources, 23% PROSAUDE and 24% from other external partners). According to NASA, in 2011, US $26.3 million was spent in HIV specific funding, including expenditure for construction and rehabilitation of facility infrastructure and laboratories (US $13.6 million), information systems (US $7 million), drug systems (US $2.9 million), and others not specified (US $2.8 million). An additional US $32 million was spent in 2011 to train HCW and community members on HIV related topics.

Expenditure by Cost Category. Most commodities for HIV are financed by international partners. In 2014, 100% of ARVs were procured through international mechanisms such as PPM and SCMS, and financed by international donors, including PEPFAR (52%), the GFATM (45%), and UNITAID (3%). The same applied for the acquisition of rapid test kits (RTKs), financed by the GFATM (57%), PEPFAR (39%), and Clinton Health Access Initiative (CHAI) (4%), as well as reagents and other commodities for CD4 tests. Acquisition of condoms also relies heavily on international assistance through GF, PEPFAR and UNDP (90%).

GRM pays HCW salaries (estimated at US $12 million in 201[13]) and costs related to implementation (facility maintenance, transport etc.). According to the 2014 NASA, 40% of labor costs for HIV treatment in 2011 were supported by the State Budget, with an additional 8% from PROSAUDE. The

[13] MISAU, Plano Estratégico para TB

remaining 52% was made off-budget, with USG funding including personnel costs for Implementing Partners delivering programs for HIV treatment in 2011 (US $14.3 million) and MSF (US $2.3 million). Service delivery is integrated into the national health system but salaries paid to doctors by some NGOs are at levels above the national scale to cover the gaps in health workforce. US $2.4 million was spent by the USG in 2011 for labor-related expenses of Mozambican non-governmental organizations (NGO) for home-based care.

Planned Government Contributions. The government has committed to increase domestic public expenditure for HIV, TB and malaria to US $53 million in 2017, (totaling US $127 million between July 2015 and December 2017). MISAU increased its contribution by US $28.4 million in 2015, which will raise the contribution of GRM to the three diseases in 2015-2017 to 20% of its health sector contribution. The Ministry of Defense (Ministério da Defesa Nacional -MDN) remains committed to development of its military medical system.

Data Availability and Estimations. Overall health sector expenditures are estimated from MISAU the annual execution budget reports (*Relatorios de Execução Orçamental*), complemented by estimations made by WHO and UNICEF. MISAU does not track or report spending by disease category. Reporting of HIV specific funding is based on the NASA, elaborated by CNCS, which details HIV expenditure by financing source, programmatic area, beneficiary population or geographical location. Data available covers the years 2004 to 2011. HIV funding for 2012 and 2013 was estimated using the FY2015 PEPFAR Expenditure Analysis, Official Development Assistance to Mozambique Database - ODAMOZ and the Organization for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) online data bases and donor reports.

Despite positive projections, the GRM will not be able to fully cover the costs of its response to HIV (and TB and Malaria). The estimated gap from June 2015 to December 2017 reaches US $365 million, representing 36% of the Government's Health Sector Budget for the same period.

Table 1.2.1 Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support					
Community-based care, treatment, and support					
PMTCT					
HTS					
VMMC					
Priority population prevention					
Key population prevention					
OVC					
Laboratory					
SI, Surveys and Surveillance					
HSS					
Total					

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	$117,635,707	27.8%	72.2%	0.0%	0%
Rapid test kits	$11,801,866	4.8%	95.2%	0.0%	0%
Other drugs	$33,140,972	9.3%	44.9%	45.8%	0%
Lab reagents	$11,811,094	32.9%	0.0%	0.0%	0%
Condoms	$2,413,735	0.0%	0.0%	13.0%	87.0%
Viral Load commodities	$4,839,492	94.9%	5.1%	0.0%	0%
VMMC kits*	$520,386	100.0%	0.0%	0.0%	0%
MAT	$0	0.0%	0.0%	0.0%	0%
Total	$182,163,252	25%	65%	9%	1%

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$14,050,000	$11,450,000	6		Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Expand coverage and improve quality of community health activities; Training CHWs; Increased access to and use of voluntary FP contraceptive methods; Improved maternal and child survival.
USAID TB	$4,500,000	$300,000	1		Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Increased capacity of CBOs, FBOs, and NGOs to develop and manage programs that improve the quality and coverage of HIV/AIDS services.
USAID Malaria	$28,500,000	$16,220,000	3		Strengthened governance, supply chain; Improved maternal and child survival; Improved health behaviors.
Family Planning	$11,500,000	$5,650,000	6		Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Improved health behaviors; Commodities purchased including condoms, essential medicines, and diagnostics; Increased access to and use of voluntary FP contraceptive methods; Improved maternal and child survival.
USAID Nutrition	$5,700,000	$3,300,000	3		Include, but are not limited to: Increased capacity of MISAU to develop and implement nutrition-oriented policies and programs; Improved maternal and child survival; improved health behavior.
Peace Corps	$7,135,131	-	-		
Total					

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT						
DREAMS						
DREAMS Innovation						
DREAMS Test & Start-Men						
VMMC						
Viral Load						
Other PEPFAR Central Initiatives						
Other Public Private Partnership						
Total						

1.3 National Sustainability Profile

PEPFAR-Mozambique strove to make the completion of the Sustainability Index Dashboard (SID) as inclusive as possible. Consultation involved a series of nine meetings with key stakeholders including MISAU, multilateral partners, and civil society. Over 40 participants provided input and the final product was vetted by GRM during a day-long review. SID reviewers identified the following elements as sustainability weaknesses which are critical to the rapid expansion of access to HIV care and treatment: domestic resource mobilization, laboratory services, and civil society engagement. Both PEPFAR and the GFTAM have been investing in the laboratory system in Mozambique including key activities such as the construction of the National Public Health Laboratory, procurement of diagnostic machines, and procurement of reagents for viral load scale up. PEPFAR and GFTAM have also provided extensive support for sustainable health sector financing plans and increased civil society participation. All of these activities will continue to be supported in COP16. Key sustainability strengths include quality management, program planning and coordination, and utilization of performance data. Moving towards a sustainable response requires improving GRM's allocative efficiency and oversight and stewardship. It is important to note that some areas that scored green do not align to the perception of country team members, perhaps because the instrument fails to capture enough granularity and the quality of the indicators requested.

With such fundamental systemic weaknesses in the health sector, PEPFAR-Mozambique has prioritized supply chain, health information systems, and human resources for health for investment in COP16.

1.4 Alignment of PEPFAR investments geographically to disease burden draft pending

XXXXX

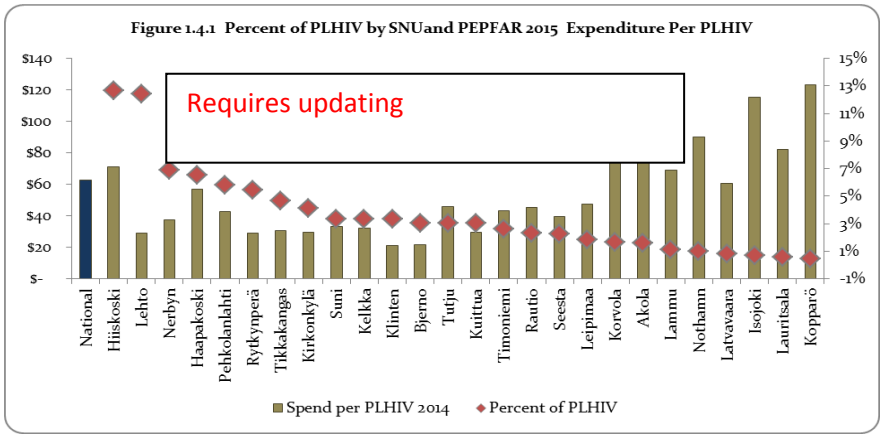
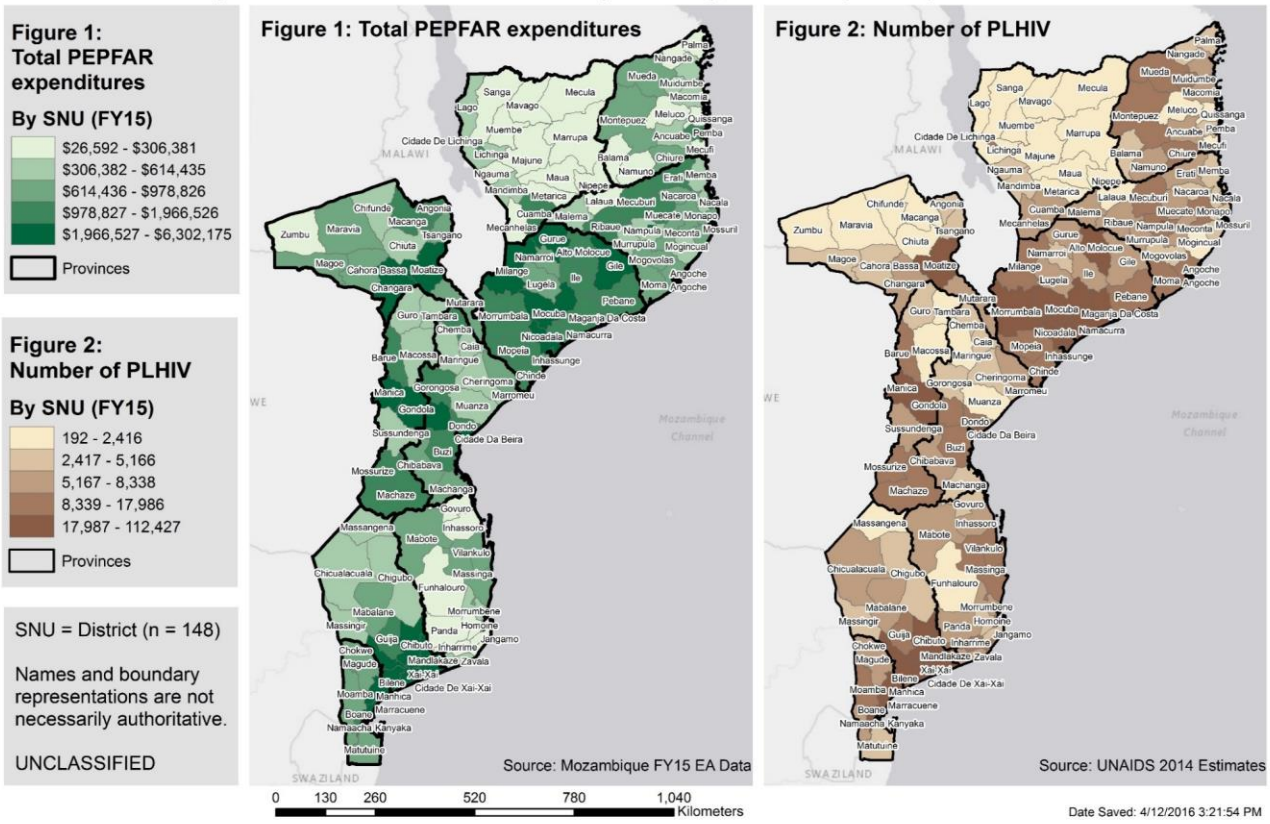


Figure 1.4.2 PEPFAR Operating Unit
Total PEPFAR Expenditures and Number of People Living with HIV (PLHIV)



1.5 Stakeholder Engagement

Host country government:

PEPFAR-Mozambique is committed to increased engagement with the Mozambican government on policy issues, data sharing, and strategic discussion to develop a shared vision for more substantial country ownership. Since April 2015, there have been significant improvements in collaboration and communication with the GRM, particularly MISAU. USG leadership enjoy regular meetings with the Minister and Vice Minister for Health, and frequent policy and program consultations with the national directors of Planning & Cooperation, Medical Assistance, Public Health,CMAM, Human Resources and heads of programs including STI/HIV and AIDS, TB, and Laboratory.

PEPFAR-Mozambique contributes to provincial planning processes and engages with Provincial Directorates for Health (*Direcção Provincial de Saúde*- DPS) to oversee program implementation and partner support at district and site level through facility site visits and also by sharing QI cycle results, Site Improvement through Monitoring Systems (SIMS) reports and program results. PEPFAR Mozambique has two national level Cooperative Agreements (G2G) with MISAU, and one with the

National Institute of Health (*Instituto Nacional Saúde*– INS). In addition, at the provincial level, PEPFAR-Mozambique has six provincial Cooperative Agreements (G2G).

PEPFAR-Mozambique also collaborates closely with the INS and the CNCS. Other ministries with which PEPFAR collaborates frequently include the Ministry of Gender, Child, and Social Action (*Ministério do Género, Criança e Acção Social* - MGCAS) and the Ministry of Education and Human Development (*Ministério da Educação e Desenvolvimento Humano* - MEDH) - all of which have critical importance to the OVC work and DREAMS and ACT initiatives. PEPFAR also engages on a periodic basis with the MDN, Ministry of Foreign Affairs and cooperation (*Ministério dos Negócios Estrangeiros e Cooperação* - MINEC), and MINEF.

This level of engagement has enhanced PEPFAR's ability to participate in policy and planning in meaningful ways, and allowed the USG to advocate on behalf of MISAU with other parts of GRM (especially MINEF and the Presidency).

Global Fund and other external donors

PEPFAR-Mozambique has engaged closely with GFTAM throughout the development of COP16. The USG plays a key role in the management of GFTAM grants via participation in the Country Coordinating Mechanism (CCM). USG is the lead of the strategic supervision working group and sits on the CCM Executive Committee. Since 2015, PEPFAR-Mozambique has a full-time Global Fund Liaison who attends all GFTAM meetings in country, communicates regularly with the Fund Portfolio Manager (FPM) in Geneva, coordinates USG technical assistance to the GFTAM, and works to harmonize the PEPFAR and GFTAM programs.

GFTAM staff (including the FPM) and the PEPFAR strategic information, HSS and supply chain leads have participated in meetings in Maputo and Washington, DC which were focused on improving collaboration and synchronizing programmatic strategies between PEPFAR and the GFTAM for the COP16 implementation period. The PEPFAR held two in-person COP16 briefings for GFTAM staff, a meeting between the FPM and the US Ambassador, and convened several technical calls focusing on specific programmatic areas during the COP planning period. The PEPFAR team shares all program plans with GFTAM prior to finalization and solicits input on key strategic pivots.

In COP16 PEPFAR-Mozambique will continue to engage with GFTAM to ensure both programs leverage their respective comparative advantages and to eliminate duplicative activities. In particular, PEPFAR will share information and solicit feedback before and after technical assistance visits, quarterly reporting, and SID. PEPFAR will also continue to work closely with GFTAM to coordinate commodities planning as Mozambique begins phased implementation of T&S.

Civil Society

For COP16 development, PEPFAR-Mozambique has been engaging with civil society since December 2015, through the Civil Society Platform for Health (Plataforma da Sociedade Civil -PLASOC), implementing partners and UNAIDS. A PEPFAR/Civil Society (CS) engagement plan was developed with CS, highlighting key activities that will mark a close collaboration and partnership throughout FY16. Representatives of the PLASOC will participate in the COP16 Review in May 2016.

PEPFAR-Mozambique's CS TWG will continue meet with the PLASOC regularly throughout the COP16 implementation period to share information as well as to solicit input into key programmatic issues and policy decision points. In COP16 this will include consultations to assist with analysis of the roll out of T&S, share guidance from the Office of the U.S. Global AIDS Coordinator (OGAC) on funding opportunities available to CS and discuss the final outcomes of the COP16 Review, and PEPFAR's Human Rights agenda.

Private Sector

The U.S. Government Public-Private Partnership (PPP) Interagency Working Group in Mozambique meets quarterly to provide a forum for communication, collaboration, and discussion of best practices and opportunities for partnership building across U.S. Agency for International Development (USAID), State Political/Economic Section, Centers for Disease Control and Prevention (CDC), and Peace Corps (PC). This platform is PEPFAR's primary point of engagement with the Private Sector. Please see Table 1.2.4 for additional information on PPPs linked to PEPFAR.

2.0 CORE, NEAR-CORE AND NON-CORE ACTIVITIES

PEPFAR-Mozambique defined core, near-core, and non-core activities for program implementation by considering the activities required for achieving sustained epidemic control, the current country investment portfolio, and gaps/bottlenecks preventing program scale up. PEPFAR is the primary funder for key activities in the national response, and core activities include combination prevention activities, aspects of community-based care, OVC and priority population prevention, and technical assistance (TA) for commodity procurement and supply chain and information systems. For COP16, PEPFAR-Mozambique re-categorized nutrition support from near-core to core, given its importance to patient adherence to treatment. The current economic situation and severe drought, expected to continue through COP16 implementation, also informed this decision. In addition, activities targeted to people who inject drugs (PWID) were included as core.

PEPFAR-Mozambique is the primary provider of TA to support care and treatment, which remains a core activity. The majority of care and treatment interventions are considered core activities with the exception of the following near-core activities: diagnosis and treatment of sexually transmitted infections (STI), cervical cancer, and Kaposi's sarcoma; some laboratory monitoring (e.g. liver function tests); expansion of TB diagnosis (training, GeneXpert scale up); some sample referral systems; expansion of radiological diagnostic capacity (x-ray machines); development of nutritional messages; and supplies for nutritional screening in high HIV burden areas. COP16 will not fund any activities categorized as non-core. (See Appendix A for details of the Core/Near Core/Non-Core activities).

3.0 GEOGRAPHIC AND POPULATION PRIORITIZATION

PEPFAR-Mozambique estimated PLHIV at the sub-national level using available epidemiological, programmatic, and demographic data in a stepwise process. This process mirrors the recent OGAC method that takes existing Sub-National Unit (SNU). Spectrum estimates and apportions and disaggregates them down to the SNU2 level based on relative burden of disease as estimated from PMTCT programmatic data. First, official Spectrum files from 2015 (2014 estimates were adjusted to reflect the move to CD4-500 in 2016 and T&S from 2017 onwards, and 2016 and 2017 PLHIV estimates were captured. Second, INSIDA 2009 Provincial HIV 15-49 estimates and provincial census projections were used to calculate the relative burden of disease in each province, and used to push down Spectrum PLHIV regional estimates to the provincial level. Third, MISAU calendar year ANC prevalence data and district census projections were used to calculate the relative burden of disease in each district, and to attribute PLHIV burden down to the district level. Please note that there are limitations to these estimates especially when extrapolated to district level.

In COP15, PEPFAR-Mozambique prioritized 78 (of 148) districts for scale-up based on high HIV burden.[14] At the beginning of FY16, the estimated gap to achieve saturation in these districts was 495,243 persons[15]. The technical team recalculated the total number of PLHIV in each district nationally taking into consideration the most recent UNAIDS Spectrum estimates and the latest ANC program prevalence data, and found that the resulting reassessment resulted in minimal change of the existing prioritization (affecting the categorization of districts with < 5% of PLHIV nationally). Given that the current list of prioritized districts was determined with MISAU and that more precise estimates of HIV burden by district are anticipated later in 2016, PEPFAR-Mozambique elected to make no changes to the overall prioritization of scale-up and sustained districts.

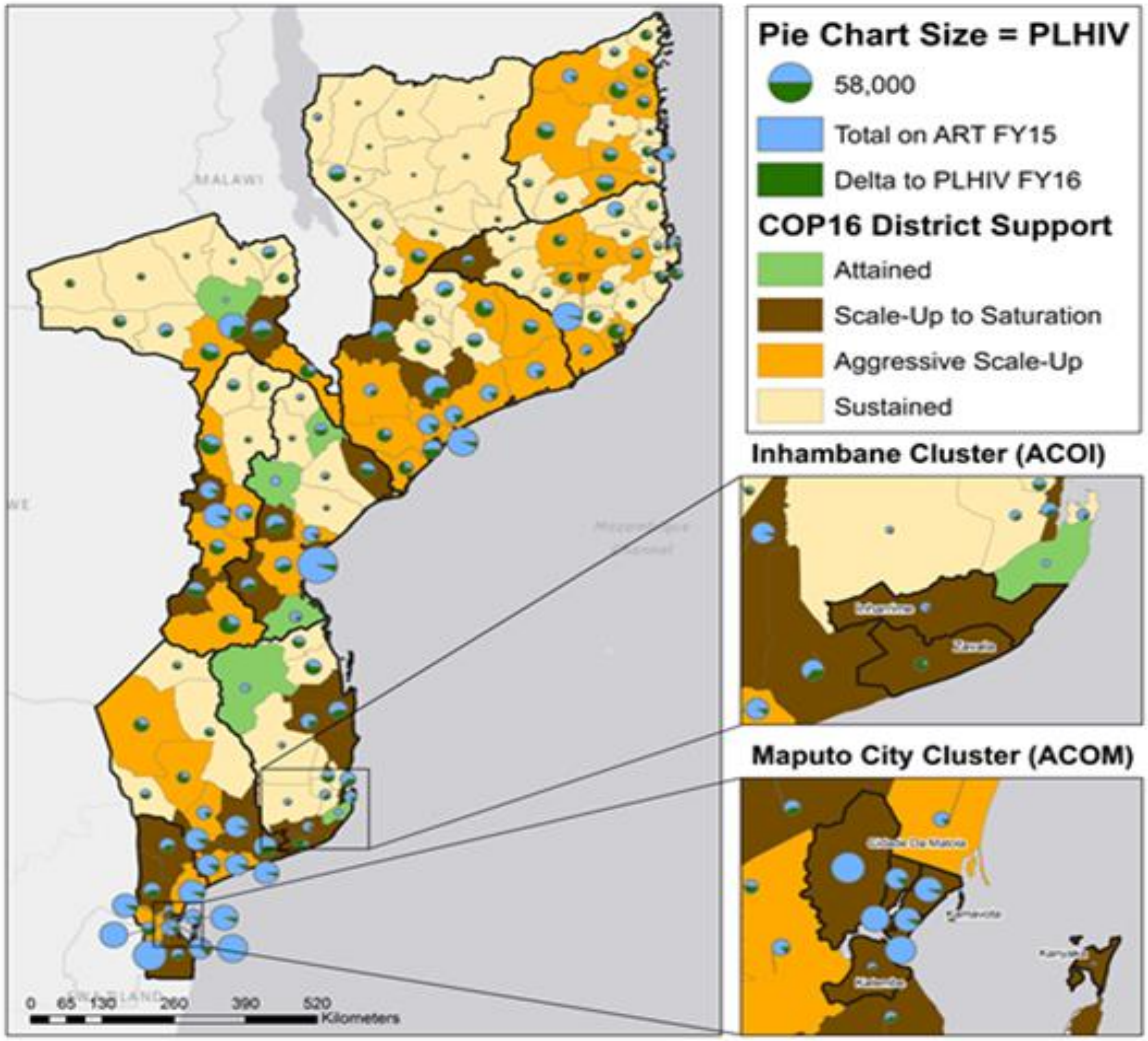
For pediatrics, the number of estimated children living with HIV decreased by 8% from 2014 to 2015, from 180,701 (Spectrum 2014) to 165,585 (Spectrum 2015). The number of estimated children eligible for ART under the current guidelines decreased from 128,924 to 77,202 (47% of pediatric PLHIV). SNU estimates for pediatric PLHIV were derived from the estimated adult prevalence rates and from the estimated number of children in the SNU. Prioritization for this population followed the prioritization determinations made based on the overall targets.

[14] 86% of the PLHIV nationally reside in these districts.
[15] MISAU and PEPFAR data.

Technical teams conducted a saturation analysis to determine if districts deemed to be near saturation should be re-categorized as sustained (now "attained"). Districts with high coverage and districts with low coverage that are adjacent and appear to have a shared catchment area (based on patient health-seeking behavior) were brought into a single cluster. With this analysis, PEPFAR-Mozambique created two new clusters: A Cluster of Inhambane (ACOI), made up of Inharrime and Zavala, and A Cluster of Maputo (ACOM) made up of Cidade de Maputo (7 sub-districts) and Cidade da Matola. With this clustering, the overall number of scale-up districts was adjusted from 77 to 78, as one sub-district of Cidade de Maputo, Katembe, then moved from sustained to scale up. (See Figure 3.0.1 below which illustrates these clusters and coverage for each of these districts individually and clustered).

PEPFAR-Mozambique developed targets using estimates of coverage at the cluster level for treatment, HIV counseling and testing (HTC), and voluntary medical male circumcision (VMMC). Targets for clusters were allocated to component districts proportional to FY15 achievements.

Figure 3.0.1: Inhambane and Maputo Clusters

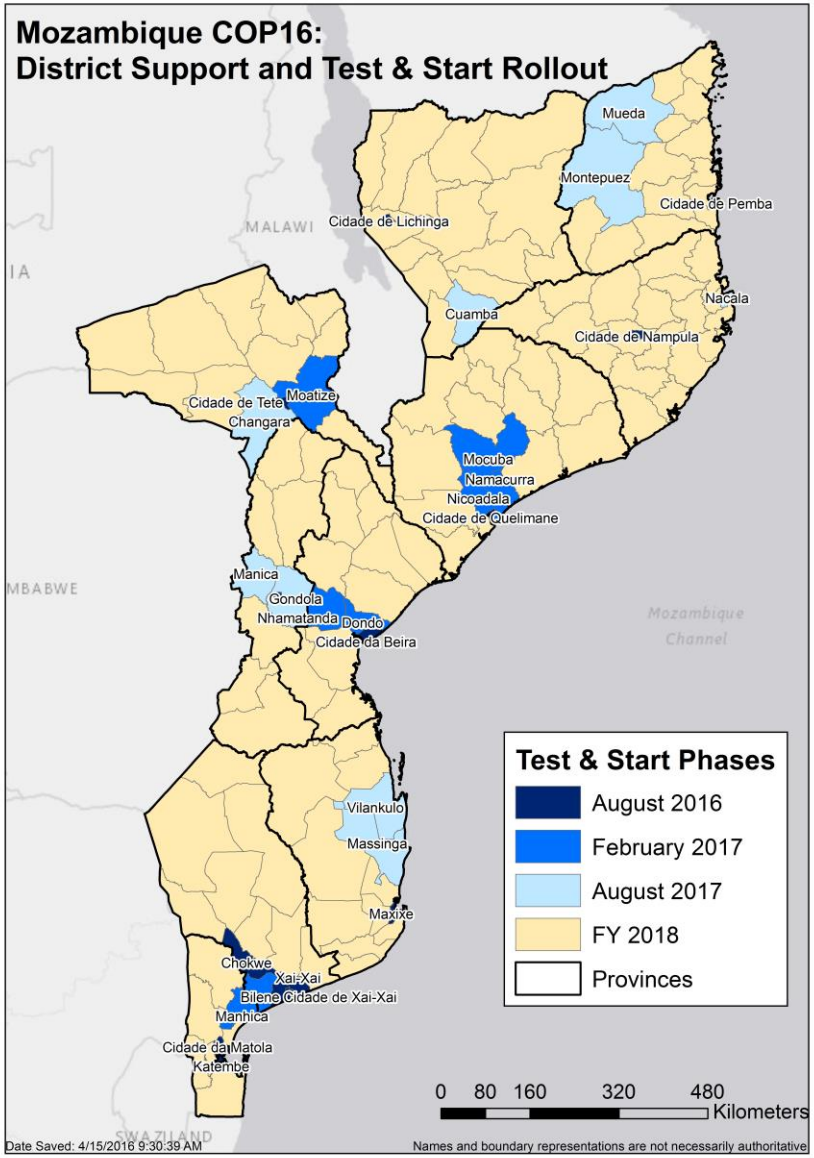


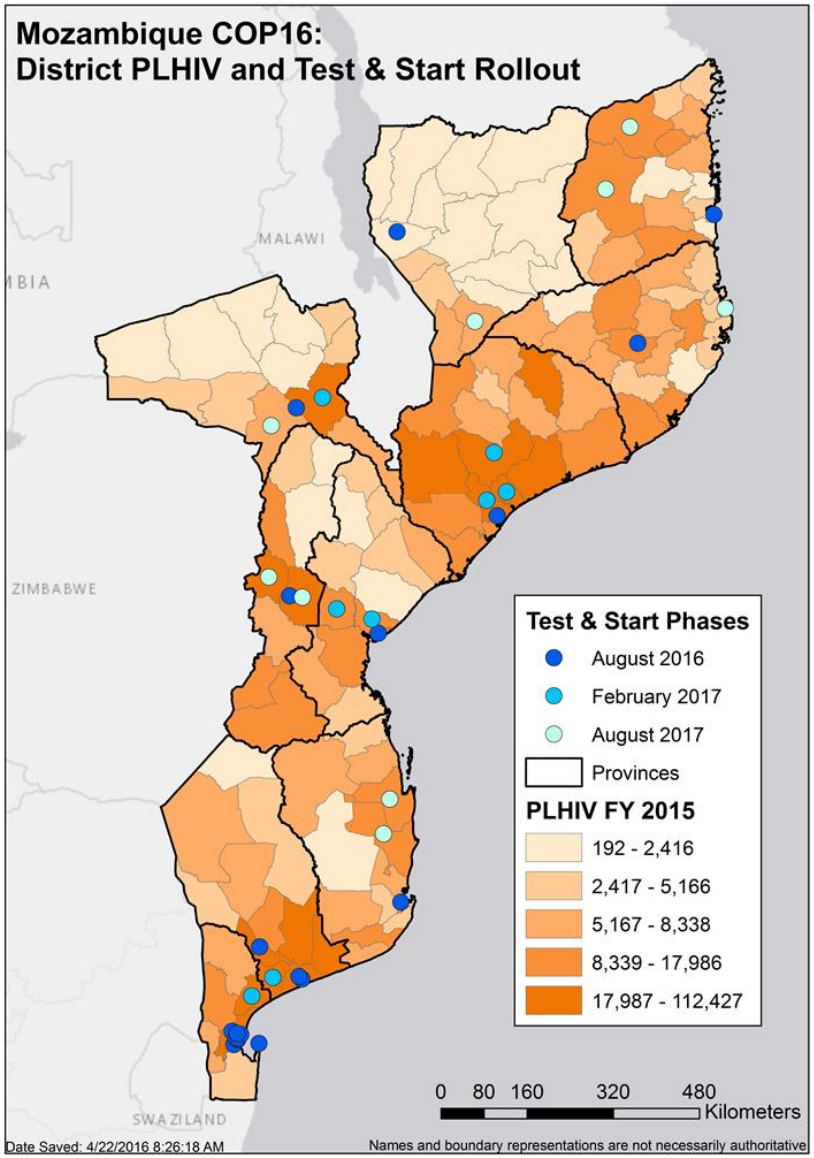
In March 2016, MISAU revised the threshold for ART eligibility to CD4>500 and committed to phased implementation of T&S with national implementation by FY18. MISAU will roll out T&S in 36 districts in FY16-FY17, including all provincial capitals (except Cidade de Inhambane which was replaced with Maxixe as it has higher burden and lower coverage, all 5 DREAMS districts, and additional districts selected based on high burden of HIV and/or high burden of key populations. Together, these 36 districts represent 60% of PLHIV in Mozambique (947,353).

Phase 1 of T&S implementation begins in August 2016 and will include all provincial capitals (12 districts, including all sub-districts of Maputo city), and will cover 629,927 PLHIV, (40% of all PLHIV). **Phase 2** will begin in February 2017, and will add eight of the next highest burden districts in each province, covering an additional 195,099 PLHIV (52% of all PLHIV will be covered). **Phase 3** will begin in August 2017, and will add another 9 districts, covering an additional 122,327 PLHIV and bringing the overall coverage of T&S to 60% of PLHIV in Mozambique. Following Phase 3, GRM will roll out T&S throughout Mozambique. (Please see Appendix D for the T&S phased implementation plan.)

District targets were set using updated treatment guidelines and the potentiality to achieve saturation, as described in Section 4.1. The overall number of districts achieving saturation by FY18 was calculated using 80% as the threshold (vs. 73% in COP15). Please see district categorization in the table below:

COP15		**COP16**	
Scale-up Saturation (80% coverage by FY15)	1	Attained (>80% coverage in FY15)	6
Scale-up Aggressive – Tier 1 (73% coverage by FY17)	39	Scale-up Saturation (80% coverage by FY18)	34
Scale-up Aggressive – Tier 2 (<73% coverage by FY17)	37	Scale-up Aggressive (<80% coverage by FY18)	44
Sustained	71	Sustained	64


Mozambique COP16:
District Support and Test & Start Rollout
Mueda
Montepuez
Cidade de Pemba
Cidade de Lichinga
MALAWI
Nacala
Cuamba
Cidade de Nampula
Moatize
Cidade de Tete
Changara
Mocuba
Namacurra
Nicoadala
Cidade de Quelimane
Manica
Gondola
Nhamatanda
Dondo
Cidade da Beira
Mozambique Channel
Vilankulo
Massinga
Maxixe
Chokwe
Xai-Xai
Bilene
Cidade de Xai-Xai
Manhica
Cidade da Matola
Katembe
SWAZILAND
Test & Start Phases
August 2016
February 2017
August 2017
FY 2018
Provinces
0 80 160 320 480
Kilometers
Date Saved: 4/15/2016 9:30:39 AM
Names and boundary representations are not necessarily authoritative


Mozambique COP16:
District PLHIV and Test & Start Rollout
MALAWI
ZIMBABWE
SWAZILAND
Test & Start Phases
August 2016
February 2017
August 2017
Provinces
PLHIV FY 2015
192 - 2,416
2,417 - 5,166
5,167 - 8,338
8,339 - 17,986
17,987 - 112,427
0 80 160 320 480
Kilometers
Date Saved: 4/22/2016 8:26:18 AM
Names and boundary representations are not necessarily authoritative

4.0 PROGRAM ACTIVITIES FOR EPIDEMIC CONTROL IN SCALE-UP LOCATIONS AND POPULATIONS

4.1 Targets for scale-up locations and populations

Development of overall treatment targets:

In order to maximize progress towards achieving UNAIDS 90-90-90 goals, PEPFAR-Mozambique prioritized activities to maximize ART coverage for all PLHIV in the highest burden districts. The team used the following data sources to determine COP16 targets in priority areas: 1) new epidemiologic data, 2) updates to national guidelines, and 3) past achievements and feasibility of further acceleration of scale-up.

While the overall list of 78 scale-up districts did not change between COP15 and COP16 (except for the addition of Katembe as described in Section 3.0), current ART coverage and plans for phased implementation of T&S informed the development of targets and determination of which districts would be scale-up-to-saturation in COP16.

PEPFAR-Mozambique, together with MISAU, reviewed accomplishments during implementation of the Mozambican Acceleration Plan and roll-out of Option B+ to estimate feasible scale-up of T&S, and concluded that 15-20% growth of the total number of people on ART each year could be achieved in scale-up districts, with higher growth expected in districts that are currently low coverage and lower growth in districts nearing saturation.

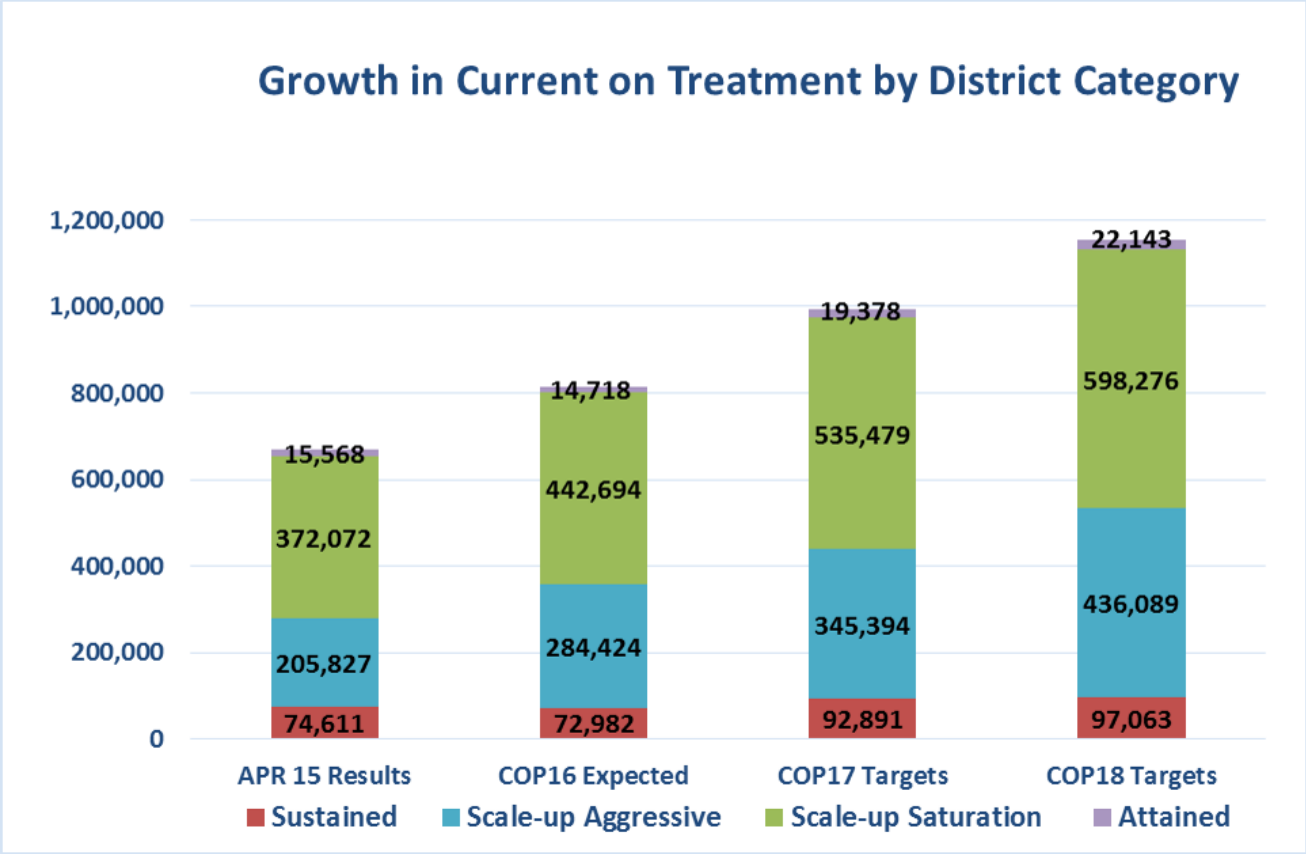
Taking this into account, all districts with at least 45% coverage in FY15 (PEPFAR APR15 data) are targeted to reach 80% coverage or saturation by FY18, using the following formula:

Existing coverage in FY15	Targeted coverage in FY17	Targeted coverage in FY18
>60%	80%	90%
>45-60%	73%	80%
>35-45%	60-66%	73-76%
>20-35%	50%	66%
≤20%	40%	60%

Districts included in Phase 1 of T&S were targeted for an additional 5% growth, based on the assumption that at least a quarter of those currently listed as pre-ART would be passively enrolled. Based on these

assumptions, 993,141 patients will be on ART in Mozambique by the end of 2017, of which 835,509 will be in scale up districts. Figure 4.1.1 shows total number of targets by district category.

Figure 4.1.1: Treatment Targets and Coverage by Revised District Category



The greatest challenge for reaching these ambitious targets is retention of PLHIV on treatment. Strategies to improve retention are described in Sections 4.6 and 4.8.

Specific populations prioritized for intensive service provision in COP16 include children <15yrs, adolescent females, older men, patients at increased risk for TB/HIV, and key populations.

Children <15yrs are a challenging group as the current coverage (39%) and retention (64%) are both lower than the national average. In line with the on-going implementation of the ACT initiative, aggressive targets were developed for this group as described below.

Pediatric Treatment Targets:

Currently, Mozambique provides T&S for all children <5 and treatment for children 5-14 based on a CD4 threshold of 500 cells/mm^3 or WHO Stage III or IV. Based on these criteria and the latest Spectrum

estimates[16], PEPFAR's FY16 targets exceed the number of eligible children. Thus, the only way to substantially increase the number of children on treatment in FY17 is by altering the eligibility criteria to provide T&S to children 5-14. This will be done by districts in parallel with the phases of implementation of T&S.

FY17 targets for TX_CURR <15 are based on the current number on ART at the end of FY15, adjusted to ensure that targets do not exceed estimated district-level eligibility ceilings by more than 50%. The FY17 TX_CURR target for sustained districts was raised by 20% (10% per year) from APR15 results. The FY17 TX_CURR target for scale-up districts is set to increase by 90% from the APR15 results in Phase 1 districts, by 70% in Phase 2 districts, and by 50% in the remaining scale-up districts. Using this method, the target for the total number of children on ART is 83,860 in FY17, an increase of 63% (32,377) from the APR15 TX_CURR result of 51,483. Growth from APR13 to APR14 was 10,760, and growth from APR14 to APR15 was 12,113.

Two key challenges to reaching this target are finding HIV-infected children and retaining those identified. Strategies for addressing these challenges are further discussed in Section 4.9.

HIV Counseling and Testing (HTC) Targets:

PEPFAR calculated targets for adult and pediatric HTC in parallel. Targets were then developed for the number of new adult and pediatric HIV positive diagnoses to meet the targeted number of new adult and pediatric initiating treatment after accounting for incomplete linkage to care, and assumed entry of 25% and 15% of people in pre-ART to treatment for test and start and non-test and start districts, respectively. Linkage at the provincial level was estimated based on the historical ratio between number of new HIV diagnoses and new entrants into care.

- For provider-initiated counseling and testing (PICT) and community-based testing, PEPFAR-Mozambique assumed a 20% improvement in HIV testing yield based on planned initiatives.
- Since co-located voluntary-counseling and testing (VCT) has been the highest-yield high-volume testing modality in Mozambique, the team tried to identify every opportunity for addition of co-located VCT. VCT targets were added to every site deemed feasible in a scale-up district with PICT but no VCT, estimating volume and yield based on other sites in the district.
- Index-case testing targets are based on 1.75 times the new on treatment target, based on the most common method of index case identification and assumptions about numbers of partners and acceptance rate of the modality. PEPFAR-Mozambique manually reviewed outlying index-case targets where the modality accounted for ≥ 50% of the HTC portfolio, and manually revised targets for 5 districts. Index-case targets are allocated as follows: 50% to VCT and 50% to community-based testing (CBT). CBT targets are solely comprised of index-case and Key Populations (KP) targets.

[16] Spectrum estimates for children in Mozambique are based on very limited data and are thus unreliable, but this is the best information we have. See Section 3.0 for further discussion.

For children aged <15, PEPFAR-Mozambique estimated the number of HIV tests required to make targeted pediatric HIV positive diagnoses based on 50% of the positivity rate in the antenatal clinic matched at the district level.

Key Populations Targets:

Rigorous KP size estimates based on integrated behavioral and biological survey (IBBS) data are only available in several large urban areas, although programmatic mapping activities are planned in COP16 to fill this gap. For COP16, target districts were selected based on IBBS data and expert knowledge regarding KP hotspots, and KP population size was estimated from IBBS and general population data. Targets for commercial sex workers (CSW), MSM and prisoners were set based on a goal of reaching 80% of the population by the end of FY18.

PMTCT Targets:

For PMTCT, revised district population estimates allocated to the SNU by fertility rates were used to set targets. The PMTCT program set high targets for pregnant women tested for HIV (95%), HIV+ pregnant women on ART (95%), HIV-exposed infants tested (85% in scale-up districts and 75% in sustained districts), and HIV-infected infants linked to ART (95%). Specific activities to address challenges with early infant diagnosis (EID) implementation and to improve linkage and testing to HIV exposed are discussed in Section 4.4 and Table 6.2.3.

Table 4.1.1 ART Targets in Scale-up **Sub-national Units for Epidemic Control**

SNU	[Specify SNUs for focus]	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) *TX_CURR*	Newly initiated (APR FY 17) *TX_NEW*	ART Coverage (APR 17)
Alto Molocue	ScaleUp Agg	10,523	4,122	3,646	4,964	1,667	47%
Ancuabe	ScaleUp Agg	6,546	3,341	2,042	3,381	708	52%
Angoche	ScaleUp Agg	8,832	3,113	3,968	3,506	1,016	40%
Barue	ScaleUp Agg	13,788	7,026	3,120	8,163	2,542	59%
Bilene	ScaleUp Agg	31,483	18,440	7,202	18,817	4,065	60%
Boane	ScaleUp Agg	22,765	10,154	2,708	13,584	5,461	60%
Buzi	ScaleUp Agg	8,935	4,270	1,056	5,483	2,067	61%
Caia	Attained	5,090	3,486	0	4,815	2,200	95%
Changara	ScaleUp Agg	11,124	6,057	1,761	7,342	2,496	66%
Chibabava	ScaleUp Sat	7,074	3,739	619	5,038	2,047	71%
Chibuto	ScaleUp Sat	26,341	17,065	2,353	18,783	5,131	71%
Chicualacuala	ScaleUp Agg	6,915	3,068	1,522	3,421	966	49%
Chinde	ScaleUp Agg	6,456	2,529	2,165	3,118	1,095	48%
Chiure	ScaleUp Agg	10,292	5,253	1,839	6,356	2,154	62%
Chiuta	Attained	1,046	1,212	0	1,400	491	134%

Table 4.1.1 ART Targets in Scale-up **Sub-national Units for Epidemic Control**

SNU	[Specify SNUs for focus]	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) *TX_CURR*	Newly initiated (APR FY 17) *TX_NEW*	ART Coverage (APR 17)
Chokwe	ScaleUp Sat	32,493	23,069	0	27,619	9,164	85%
Cidade Da Beira	ScaleUp Sat	76,701	40,539	5,825	55,818	23,387	73%
Cidade Da Matola	ScaleUp Sat	130,497	64,379	6,305	69,310	17,808	53%
Cidade De Chimoio	ScaleUp Sat	40,296	22,710	127	31,028	12,860	77%
Cidade De Lichinga	ScaleUp Sat	8,715	4,081	0	6,699	3,435	77%
Cidade De Nampula	ScaleUp Sat	38,603	19,867	3,258	24,134	8,240	63%
Cidade De Pemba	ScaleUp Agg	19,155	7,407	4,464	10,034	4,109	52%
Cidade De Quelimane	ScaleUp Agg	46,070	26,350	5,698	27,124	6,044	59%
Cidade De Tete	ScaleUp Sat	23,601	15,576	0	18,240	5,779	77%
Cidade De Xai-Xai	ScaleUp Sat	29,280	18,969	1,957	21,988	6,813	75%
Cuamba	ScaleUp Agg	7,760	3,285	952	4,654	2,026	60%
Dondo	ScaleUp Agg	20,767	9,924	3,287	13,706	5,767	66%
Gile	ScaleUp Agg	7,302	2,861	2,261	3,334	1,045	46%
Gondola	ScaleUp Agg	25,798	9,958	7,308	12,899	4,932	50%
Gorongosa	Attained	2,171	2,648	0	3,429	1,443	158%
Guija	ScaleUp Agg	16,088	7,138	3,643	9,653	3,942	60%
Inharrime	ScaleUp Sat	3,452	1,881	373	2,597	1,092	75%
Inhassunge	ScaleUp Agg	11,127	4,359	3,886	5,033	1,546	45%
Jangamo	Attained	1,954	1,755	0	2,197	881	112%
Kamavota	ScaleUp Sat	36,240	27,900	4,365	31,315	8,994	86%
Kamaxakeni	ScaleUp Sat	35,856	27,605	3,401	30,266	8,182	84%
Kampfumu	ScaleUp Sat	16,584	12,768	6,864	18,137	7,923	109%
Kamubukwana	ScaleUp Sat	33,385	25,702	2,452	27,621	7,059	83%
Kanyaka	ScaleUp Sat	648	499	91	570	171	88%
Katembe	ScaleUp Sat	2,712	2,088	222	2,262	591	83%
Mabalane	ScaleUp Agg	4,785	2,123	1,084	2,871	1,173	60%
Mabote	Attained	2,935	2,729	0	3,656	1,609	125%
Machanga	Attained	4,332	2,888	0	3,881	1,570	90%
Machaze	ScaleUp Agg	12,976	5,009	2,833	7,786	3,778	60%
Macomia	ScaleUp Agg	5,488	2,122	1,825	2,508	811	46%
Maganja Da Costa	ScaleUp Agg	23,613	9,250	8,010	11,312	3,912	48%
Magude	ScaleUp Sat	7,121	3,513	0	4,942	2,131	69%
Malema	ScaleUp Sat	3,887	2,000	316	2,676	1,076	69%
Mandlakaze	ScaleUp Sat	15,357	10,903	1,510	11,151	2,429	73%
Manhiça	ScaleUp Agg	36,514	18,014	0	22,784	8,373	62%

Table 4.1.1 ART Targets in Scale-up **Sub-national Units for Epidemic Control**

SNU	[Specify SNUs for focus]	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) *TX_CURR*	Newly initiated (APR FY 17) *TX_NEW*	ART Coverage (APR 17)
Manica	ScaleUp Sat	20,059	11,305	1,771	14,643	5,599	73%
Marracuene	ScaleUp Agg	18,335	8,178	1,000	10,884	4,342	59%
Marromeu	ScaleUp Sat	8,258	4,365	729	6,028	2,536	73%
Massinga	ScaleUp Sat	8,329	4,974	0	6,403	2,424	77%
Matutuine	ScaleUp Sat	4,593	2,266	0	3,184	1,371	69%
Maxixe	ScaleUp Sat	7,745	4,625	174	6,053	2,353	78%
Mecuburi	ScaleUp Agg	5,061	1,784	1,787	2,496	1,069	49%
Milange	ScaleUp Sat	14,248	8,149	0	10,120	3,601	71%
Moamba	ScaleUp Sat	8,320	4,105	0	5,794	2,510	70%
Moatize	ScaleUp Sat	12,856	8,485	0	10,928	4,140	85%
Mocimboa Da Praia	ScaleUp Agg	6,577	2,543	2,245	3,053	1,019	46%
Mocuba	ScaleUp Sat	19,316	12,107	287	13,680	3,994	71%
Moma	ScaleUp Agg	12,859	3,626	5,844	4,972	2,071	39%
Monapo	ScaleUp Agg	4,321	2,224	560	2,702	923	63%
Montepuez	ScaleUp Agg	9,450	3,654	2,760	4,371	1,448	46%
Mopeia	ScaleUp Agg	6,452	2,528	2,180	3,100	1,078	48%
Morrumbala	ScaleUp Agg	18,095	5,671	7,978	6,829	2,292	38%
Mossurize	ScaleUp Sat	8,804	4,962	402	6,427	2,458	73%
Muecate	ScaleUp Agg	3,508	1,237	950	1,718	729	49%
Mueda	ScaleUp Agg	16,245	6,281	5,130	7,484	2,459	46%
Muidumbe	ScaleUp Agg	9,399	3,634	3,263	4,488	1,581	48%
Mutarara	ScaleUp Agg	7,609	3,139	1,661	4,565	2,054	60%
Nacala	ScaleUp Agg	13,142	4,633	4,550	6,571	2,865	50%
Namaacha	ScaleUp Agg	6,371	3,143	0	3,705	1,191	58%
Namacurra	ScaleUp Agg	28,932	11,334	9,889	13,785	4,718	48%
Nampula	ScaleUp Agg	5,684	1,603	2,536	2,274	991	40%
Nhamatanda	ScaleUp Sat	11,778	6,651	75	9,422	4,102	80%
Nicoadala	ScaleUp Agg	33,453	13,105	10,835	16,539	6,055	49%
Nlhamankulu	ScaleUp Sat	22,266	17,142	5,375	21,347	7,633	96%
Pebane	ScaleUp Agg	26,149	8,195	10,861	9,843	3,287	38%
Sussundenga	ScaleUp Agg	7,652	3,899	649	5,050	1,931	66%
Vilankulo	ScaleUp Sat	10,419	5,678	987	7,276	2,734	70%
Xai-Xai	ScaleUp Agg	29,081	18,840	4,905	19,129	4,057	66%
Zavala	ScaleUp Sat	5,557	3,028	495	3,979	1,557	72%

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts*									
Entry Streams for ART Enrollment	**Tested for HIV (APR FY17)**			**Identified Positive (APR FY17)**			**Newly initiated (APR FY 17) *TX_NEW***		
	Total	**Adult**	**Pediatrics**	**Total**	**Adult**	**Pediatrics**	**Total**	**Adult**	**Pediatrics**
Pre-Art							**80,969**		
Facility-Based HIV Testing	**4,657,536**	**3,820,492**	**837,044**	**441,130**	**332,218**	**25,175**			
Antenatal Clinic 1st Test	1,076,423			88,939			63,847		
Labor and Delivery	191,300			1,991					
Early Infant Diagnosis	80,358			4,843					
Infant Rapid	65,253			3,276					
Tuberculosis	29,994	3,820,492	837,044	8,663	332,218	25,175			
VMMC	258,178			3,359					
Facility Index-Case	214,212			23,255					
Other PITC	2,086,248			187,442					
Co-located VCT	735,534			123,435					
							200,575	165,091	35,484
Community-Based HIV Testing	**275,609**	**139,124**	**136,485**	**29,231**	**26,342**	**6,839**			
Community Index Case	214,596			23,448					
Key Populations	22,381			2,292					
Prisoner	9,446			1,040					
Non-DREAMS Adolescent Girls and Young Women	1,280	139,124	136,485	325	26,342	6,839			
DREAMS Additional Community	27,906			2,126					
Community Mobile	12,344								
Total	**4,933,145**	**3,959,616**	**973,529**	**470,361**	**358,560**	**32,014**	**345,391**		

*Current values are shown both for component targets as well as summary targets. In some cases components do not sum to summary values, e.g. early infant diagnosis testing has been mistakenly left out of the current facility-based HIV testing target. This process of data cleaning is ongoing and expected to be completed prior to COP finalization.

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts							
Province	**District**	**Population Size Estimate**		**Current Coverage**	***VMMC_CIRC***		**Expected Coverage**
		(SNUs)		**(date)**	**(in FY17)**		**(in FY17)**
		Total male population	**Total male population, age 15-29**		**FY16 Expected VMMC_CIRC**	Expected VMMC_CIRC, age 15-29	**FY16 Expected VMMC_CIRC**
Zambezia	Alto Molocue	180,702	45978		6,354	4,448	66%
Manica	Barue	109,158	30556		5,480	3,836	21%
Gaza	Bilene	78,177	23025		1,084	759	68%
Maputo	Boane	74,739	21111		464	325	100%
Sofala	Buzi	90,200	24406		11,816	8,271	60%
Tete	Cahora Bassa	61,272	18175		4,702	3,292	10%
Sofala	Caia	70,336	16862		7,940	5,558	16%
Tete	Changara	96,764	27055		6,457	4,520	23%
Sofala	Chibabava	60,654	13498		3,258	2,281	45%
Gaza	Chibuto	98,925	26381		2,245	1,571	57%
Gaza	Chicualacuala	20,460	5700		1,874	1,312	26%
Zambezia	Chinde	64,830	15014		1,390	973	73%
Gaza	Chokwe	91,339	25727		811	568	75%
Sofala	Cidade Da Beira	231,684	81575		3,506	2,454	72%
Maputo	Cidade Da Matola	447,365	143363		19,129	13,391	70%
Manica	Cidade De Chimoio	158,700	51205		5,787	4,051	36%
Zambezia	Cidade De Quelimane	121,599	48010		10,292	7,205	117%
Tete	Cidade De Tete	107,128	34985		3,395	2,377	49%
Gaza	Cidade De Xai-Xai	59,452	19835		804	563	77%
Sofala	Dondo	86,689	28995		1,364	955	89%
Zambezia	Gile	97,694	23013		5,604	3,922	48%
Manica	Gondola	169,303	46059		8,441	5,909	23%
Sofala	Gorongosa	76,139	18573		7,552	5,287	22%
Gaza	Guija	42,648	11109		812	569	94%
Zambezia	Gurue	199,008	54504		8,462	5,923	58%
Zambezia	Ile	156,308	32854		9,874	6,912	47%
Zambezia	Inhassunge	48211	13308		3,802	2,661	77%
Maputo Cidade	Kamavota	166,042	50773		1,246	872	95%
Maputo Cidade	Kamaxakeni	113,382	39474		9,654	6,758	60%

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts							
Province	**District**	**Population Size Estimate**		**Current Coverage**	***VMMC_CIRC***		**Expected Coverage**
		(SNUs)		**(date)**	**(in FY17)**		**(in FY17)**
		Total male population	**Total male population, age 15-29**		**FY16 Expected VMMC_CIRC**	Expected VMMC_CIRC, age 15-29	**FY16 Expected VMMC_CIRC**
Maputo Cidade	Kampfumu	53,880	17612		1,657	1,160	175%
Maputo Cidade	Kamubukwana	172,700	54035		16,435	11,504	58%
Gaza	Mabalane	18,553	5096		1,399	979	30%
Manica	Machaze	58,362	12836		3,820	2,674	13%
Zambezia	Maganja Da Costa	147,799	33319		8,479	5,935	51%
Gaza	Mandlakaze	82,718	20593		3,236	2,265	49%
Maputo	Manhiça	121,556	33398		3,126	2,188	84%
Manica	Manica	140,963	43046		3,818	2,672	52%
Maputo	Marracuene	68,382	18937		3,738	2,617	63%
Sofala	Marromeu	85,611	23274		3,462	2,423	63%
Maputo	Matutuine	20,083	5212		1,184	829	62%
Zambezia	Milange	309640	73968		13,036	9,125	58%
Tete	Moatize	168,679	44658		11,456	8,019	21%
Zambezia	Mocuba	187,383	49888		5,718	4,003	85%
Zambezia	Mopeia	75,865	17217		923	646	83%
Zambezia	Morrumbala	224,625	50134		11,820	8,274	52%
Manica	Mossurize	124,388	32653		8,170	5,719	11%
Tete	Mutarara	132,546	29099		11,783	8,248	3%
Zambezia	Namacurra	126,530	34303		6,742	4,720	52%
Sofala	Nhamatanda	136,829	38706		5,008	3,506	52%
Zambezia	Nicoadala	126261	34869		4,950	3,465	71%
Maputo Cidade	Nlhamankulu	77,739	27691		1,686	1,180	145%
Zambezia	Pebane	110,995	24692		5,967	4,177	50%
Gaza	Xai-Xai	114,278	32011		1,990	1,393	60%
Total		**6,265,273**	**1,748,370**		**293,200**	**205,240**	

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control					
Province	District	**Target Populations** [Specify target populations for focus] *Indicator Codes include PP_PREV and KP_PREV.* ***(CSW)***	**Population Size Estimate** (scale-up **SNUs)**	**Coverage Goal (in FY17)**	**FY17 Target**
Cabo Delgado	Chiure		**880**	**50%**	**440**
Cabo Delgado	Cidade De Pemba		**1,327**	**50%**	**664**
Cabo Delgado	Mocimboa Da Praia		**942**	**50%**	**511**
Cabo Delgado	Montepuez		**613**	**50%**	**307**
Cabo Delgado	Palma		**703**	**40%**	**273**
Gaza	Bilene		**316**	**40%**	**127**
Gaza	Chokwe		**661**	**40%**	**265**
Inhambane	Cidade De Inhambane		**1,309**	**50%**	**655**
Inhambane	Massinga		**437**	**50%**	**439**
Inhambane	Maxixe		**2,152**	**50%**	**1,076**
Inhambane	Vilankulos		**1,001**	**50%**	**629**
Manica	Cidade De Chimoio		**1,862**	**40%**	**745**
Manica	Gondola		**610**	**40%**	**494**
Maputo Cidade	Kampfumu		**913**	**40%**	**766**
Maputo Cidade	Kamubukwana		**2,677**	**40%**	**1,071**
Maputo Provincia	Cidade Da Matola		**6,820**	**40%**	**2,728**
Maputo Provincia	Moamba		**222**	**40%**	**89**
Nampula	Angoche		**693**	**40%**	**278**
Nampula	Cidade De Nampula		**8,615**	**45%**	**3,877**
Nampula	Malema		**378**	**40%**	**152**
Nampula	Meconta		**284**	**40%**	**562**
Nampula	Moma		**208**	**40%**	**84**
Nampula	Nacala		**3,350**	**45%**	**1,508**
Niassa	Cidade de Lichinga		**1,319**	**40%**	**528**
Niassa	Cuamba		**650**	**40%**	**260**
Sofala	Cidade Da Beira		**7,299**	**40%**	**2,920**
Tete	Changara		**1,134**	**40%**	**454**
Tete	Cidade De Tete		**1,360**	**40%**	**544**
Tete	Moatize		**327**	**40%**	**131**
Zambezia	Cidade De Quelimane		**1,580**	**40%**	**632**
Zambezia	Mocuba		**1,368**	**40%**	**548**
Total			**52,010**	**46%**	**23,757**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control					
		[Specify target populations for focus] *Indicator Codes include PP_PREV and KP_PREV. (MSM)*			
Province	District		**Population Size Estimate** (scale-up **SNUs)**	**Coverage Goal (in FY17)**	**FY17 Target**
Cabo Delgado	Chiure		197	**50%**	**99**
Cabo Delgado	Cidade De Pemba		881	**50%**	**441**
Cabo Delgado	Mocimboa Da Praia		234	**50%**	**117**
Cabo Delgado	Montepuez		383	**50%**	**192**
Cabo Delgado	Palma		206	**40%**	**82**
Gaza	Bilene		166	**40%**	**66**
Gaza	Chokwe		294	**40%**	**118**
Inhambane	Cidade De Inhambane		310	**50%**	**155**
Inhambane	Massinga		91	**50%**	**46**
Inhambane	Maxixe		457	**50%**	**229**
Inhambane	Vilankulos		229	**50%**	**115**
Manica	Cidade De Chimoio		1,249	**40%**	**500**
Manica	Gondola		154	**40%**	**62**
Maputo Cidade	Kampfumu		630	**40%**	**252**
Maputo Cidade	Kamubukwana		1,751	**40%**	**700**
Maputo Provincia	Cidade Da Matola		4,657	**40%**	**1,863**
Maputo Provincia	Moamba		122	**40%**	**49**
Nampula	Angoche		411	**40%**	**164**
Nampula	Cidade De Nampula		2,654	**50%**	**1,327**
Nampula	Malema		231	**40%**	**92**
Nampula	Meconta		180	**40%**	**72**
Nampula	Moma		146	**40%**	**58**
Nampula	Nacala		928	**50%**	**464**
Niassa	Cidade de Lichinga		885	**40%**	**354**
Niassa	Cuamba		424	**40%**	**170**
Sofala	Cidade Da Beira		2,694	**40%**	**1,078**
Tete	Changara		654	**40%**	**262**
Tete	Cidade De Tete		900	**40%**	**360**
Tete	Moatize		203	**40%**	**81**
Zambezia	Cidade De Quelimane		1,071	**40%**	**428**
Zambezia	Mocuba		821	**40%**	**328**
Total			24,213	**43%**	**10,324**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
		[Specify target populations for focus] *Indicator Codes include PP_PREV and KP_PREV. (Prisoner)*		
Province	District	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY17)**	**FY17 Target**
Cabo Delgado	Cidade De Pemba	228		228
Gaza	Cidade De Xai-Xai	388		732
Gaza	Mabalane	569		853
Inhambane	Cidade de Inhambane	302		302
Inhambane	Inharrime	75		97
Manica	Cidade de Chimoio	1,871		1,871
Maputo Provincia	Cidade de Matola	2,313		2,313
Nampula	Cidade De Nampula	2,310		2,310
Nampula	Muecate	100		100
Sofala	Cidade de Beira	1,428		1,428
Zambezia	Cidade De Quelimane	650		650
Zambezia	Mocuba	253		253
Total		**10,487**		**11,137**
Grand Total		**86,710**		**45,218**

Table 4.1.5 Targets for OVC and Linkages to HIV Services							
[Specify SNUs for focus]				**Target # of active OVC (FY17 Target)**			**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target)**
Province	**District**	**Estimated # of Orphans and Vulnerable Children**		**OVC_SERV**			**OVC_KNOWNSTAT***
Cabo Delgado	Ancuabe	3,515			879		
Cabo Delgado	Chiure	5,147			1,287		
Cabo Delgado	Cidade De Pemba	8,146			3,894		
Cabo Delgado	Macomia	2,613			1,221		
Cabo Delgado	Mocimboa Da Praia	2,796			699		
Cabo Delgado	Montepuez	4,667			1,167		
Cabo Delgado	Mueda	7,550			934		
Cabo Delgado	Muidumbe	4,853			607		

Table 4.1.5 Targets for OVC and Linkages to HIV Services								
[Specify SNUs for focus]		Estimated # of Orphans and Vulnerable Children		Target # of active OVC (FY17 Target)			Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target)	
Province	District			OVC_SERV			OVC_KNOWNSTAT*	
Gaza	Bilene	28,852			3,606			
Gaza	Chibuto	25,500			3,188			
Gaza	Chicualacuala	7,596			950			
Gaza	Chokwe	29,525			9,253			
Gaza	Cidade De Xai-Xai	21,785			7,148			
Gaza	Guija	16,504			2,063			
Gaza	Mabalane	5,109			639			
Gaza	Mandlakaze	17,292			2,162			
Gaza	Xai-Xai	29,627			9,073			
Inhambane	Inharrime	5,390			6,967			
Inhambane	Massinga	12,660			1,582			
Inhambane	Maxixe	7,276			4,770			
Inhambane	Vilankulo	11,831			2,958			
Inhambane	Zavala	8,974			1,122			
Manica	Barue	16,041			4,010			
Manica	Cidade De Chimoio	33,247			8,312			
Manica	Gondola	32,466			8,117			
Manica	MACHAZE	15,948			3,987			
Manica	Manica	21,171			3,703			
Manica	Mossurize	8,621			2,582			
Manica	Sussundenga	8,815			2,204			
Maputo	Boane	28,661			7,165			
Maputo	Cidade Da Matola	119,767			14,971			
Maputo	Magude	9,714			2,428			
Maputo	Manhiça	48,452			6,057			
Maputo	Marracuene	23,929			5,982			
Maputo	Matutuine	5,859			2,574			
Maputo	Moamba	9,658			3,609			
Maputo	Namaacha	7,357			920			
Maputo Cidade	Kamavota	15,345			3,836			
Maputo Cidade	Kamaxakeni	13,716			3,179			
Maputo Cidade	Kampfumu	4,087			761			
Maputo Cidade	Kamubukwana	16,475			2,059			

Table 4.1.5 Targets for OVC and Linkages to HIV Services								
[Specify SNUs for focus]		Estimated # of Orphans and Vulnerable Children		Target # of active OVC (FY17 Target)			Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target)	
Province	District			OVC_SERV			OVC_KNOWNSTAT*	
Maputo Cidade	Kanyaka	905			113			
Maputo Cidade	Nlhamankulu	7,839			1,960			
Nampula	Angoche	15,072			3,768			
Nampula	Cidade De Nampula	56,530			14,133			
Nampula	Malema	7,449			2,688			
Nampula	Mecuburi	10,834			3,026			
Nampula	MOMA	22,868			2,859			
Nampula	Monapo	7,705			1,926			
Nampula	Muecate	6,630			829			
Nampula	Nacala	20,900			2,613			
Nampula	Nampula	10,270			3,649			
Niassa	Cidade De Lichinga	24,101			3,013			
Niassa	Cuamba	5,212			5,212			
Sofala	Buzi	14,920			3,904			
Sofala	Chibabava	12,010			3,734			
Sofala	Cidade Da Beira	80,750			41,136			
Sofala	Dondo	26,464			6,616			
Sofala	Marromeu	12,741			1,413			
Sofala	Nhamatanda	19,832			4,958			
Tete	Changara	17,114			4,278			
Tete	Cidade De Tete	24,226			8,041			
Tete	Moatize	18,253			4,851			
Tete	Mutarara	11,305			5,189			
Zambezia	Alto Molocue	13,795			4,422			
Zambezia	Chinde	10,523			1,315			
Zambezia	Cidade De Quelimane	41,456			23,464			
Zambezia	Gile	11,429			3,400			
Zambezia	Inhassunge	12,899			1,612			
Zambezia	Maganja Da Costa	32,971			8,243			
Zambezia	Milange	20,005			5,001			
Zambezia	Mocuba	29,760			7,440			
Zambezia	Mopeia	9,462			2,656			

Table 4.1.5 Targets for OVC and Linkages to HIV Services							
[Specify SNUs for focus]		Estimated # of Orphans and Vulnerable Children		Target # of active OVC (FY17 Target)			Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target)
Province	District			OVC_SERV			OVC_KNOWNSTAT*
Zambezia	Morrumbala	28,985			7,330		
Zambezia	Namacurra	35,068			8,767		
Zambezia	Nicoadala	41,751			10,438		
Zambezia	Pebane	36,051			4,506		
	Total	1,464,622			371,128		

4.0 PROGRAM AREA SUMMARIES

4.2. Priority populations prevention

4.2.1 Key Populations

For COP16, PEPFAR-Mozambique will strengthen current investments in activities targeting key populations. CSW and MSM activities will occur at community and facility levels, ensuring linkages across the continuum of care, and with emphasis on a *reach-test-treat* cascade approach. Interventions will cover 30 districts, 28 of which are among the 78 scale up districts[17]. The 22 health facilities that MISAU designated as "KP-friendly" will receive critical support and staff training in order to effectively reach these populations. USG will support IBBS (2nd round of IBBS on female sex workers), as well as update venue mapping & profiling and size estimation exercises with results to inform programming for KPs.

PEPFAR-Mozambique is currently in discussion with MISAU about the possibility of conducting a limited pilot among PWID in Maputo to include medication assisted therapy and harm reduction. Preliminary data indicates that HIV prevalence among PWID ranges between 37%-50%, and population size estimates are 847 PWID in Maputo City and 191 for Nampula City.

4.2.3. Other Priority Populations

The military is also a priority population for PEPFAR-Mozambique, with significantly higher HIV prevalence than the general population. A Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) was completed in early 2016 in Mozambique that will lead to more detailed information and analysis of the particular epidemiology of HIV with the military. The study preliminary results place the military epidemic in the north and the interventions will be reorganized accordingly. Core prevention interventions include VMMC, HTC, and GBV, in addition to aggressive scale-up of ART through mobile and fixed sites. The military will also adopt T&S.

With HIV prevalence of 25%, prisoners are also considered a priority population. PEPFAR-Mozambique will support interventions for prisoners to include training of peer educators, demand creation for HTC, VMMC, TB and STI screening and linkages to HIV care and treatment services. All prisons targeted for these interventions fall within scale-up districts.

Mobile populations including long distance truck drivers and miners are also an important group. Prevalence among truck drivers (15.4%) and miners (22.3%) is higher than the general population. This population group is expected to be reached as clients of CSW through prevention activities targeting CSWs at the community level.

4.2.4 Adolescent Girls and Young Women (AGYW)

Complementarity of COP 2016 with DREAMS Central Initiative

[17] The additional 2 are strategically important recognized KP hotspots.

In Mozambique the HIV prevalence among AGYW age 15-24 years-old is three times higher (11.1%) than their male counterparts in the same age group (3.7%). While the DREAMS proposal aligns with the GRM strategic HIV response plans, a key difference is the geographic and sub-population focus. DREAMS will work in 5 districts in 3 provinces (Gaza, Zambézia, and Sofala) with the highest HIV prevalence among young women aged 15-24 (25%),which is significantly greater than the national estimates.

The DREAMS Initiative includes evidence-based interventions with the potential to reduce HIV incidence among AGYW. Interventions focus on HIV negative AGWY who are in-school (10-19); out-of-school AGYW (15-24) who are HIV negative, pregnant/post-partum, or lactating; and socially vulnerable/hard to reach girls (10-24) and their male sex partners. The core package of interventions include HTC; social asset building; prevention of gender-based violence; provision of post-violence care services; condom promotion and availability of diverse family planning options including long-acting reversible contraceptives; and parenting and caregiver training. Programmatically, DREAMS will link with both clinical and community GBV, OVC, ACT, VMMC, and PMTCT platforms in these 5 districts. Activities build on the clinical GBV platform by expanding post-GBV care services to 43 new HFs in DREAMS districts for a total of 62, and developing a comprehensive package for post-GBV care for children and adolescents which will be expanded to non-DREAMS districts and integrated into the national GBV program supported through COP16. Linkages with the COP16 OVC platform are centered on savings groups, school-block grants, educational attainment, and care-givers' programming.

The programmatic pivot in both HTC and Care and Treatment for COP16, and the enhanced focus on reaching more male sex partners, is central to the success of the DREAMS Initiative. As Mozambique rolls out T&S, the five DREAMS districts will provide an opportunity to pilot T&S for male sex partners. With the expansion of a reproductive health platform that will reach more AGYW, we will also reach male sexual partners and strengthen linkages to VMMC and referrals to care and treatment.

4.3 Voluntary Medical Male Circumcision (VMMC)

VMMC is provided as part of a comprehensive package of core and near-core activities that includes screening of STIs, condom provision and promotion of correct and consistent use, promotion of safer sex practices, and provision of risk reduction counseling, sexual and reproductive messages for clients and accompanying family members, as well as information on VMMC surgery. In FY16, the program made a shift towards targeting the 15-29 year old age group based on modeling data suggesting a more immediate impact on the HIV epidemic.

Currently, a considerable breadth and number of activities support demand creation. Mobile clinics and partner-funded transportation for patients are used to facilitate patient access to services. In FY17, demand creation activities will continue to focus on the 15-29 target age group based on effectiveness data from FY16. In districts reaching 80% coverage in the target age group, the program will transition activities to a maintenance phase relying on circumcision of adolescents aged 10-14 years of age. Modeling data suggests that VMMC coverage is approaching 80% in Maputo City and Maputo Province as of early FY16.

PEPFAR-Mozambique will coordinate with MISAU to decrease intensity of PEPFAR support in districts which have achieved high VMMC coverage. Maintenance of safety and quality during scale-up will be essential including strengthening of adverse event reporting, exclusive utilization of dorsal slit surgical method for all patients younger than 15 years, and strengthening of quality assurance methods that function independently of implementing partners.

4.4 Preventing mother-to-child-transmission (PMTCT)

In the context of the rollout of B+, PMTCT activities have been considered to be part of treatment with ART initiation in newly diagnosed pregnant women taking place in ANC. The GRM endorsed the global initiative for elimination of vertical transmission with the objective of reducing new HIV infections in children by 90% by 2015. Long-standing challenges at MCH facilities include low rates of facility-based deliveries (54% according to DHS 2011), limited infrastructure and limited human resources. Male involvement remains challenging. Cultural factors and stigma concerns reduce uptake of exclusive breast feeding. Mozambique has a high fertility rate (5.9) and low levels of modern contraceptive use[18]. Finally, data quality overall is a challenge, as the national PMTCT M&E system is paper-based. PEPFAR supports MISAU in efforts to revise, improve and roll-out PMTCT/Maternal Child Health (MCH registers to allow longitudinal follow up of pregnant and lactating women and linking mother/infant pairs.

There is a relatively high rate (91%) of women attending at least one antenatal care (ANC) visit, however this often occurs late in pregnancy. Although ANC uptake drops off to approximately 55% by the fourth visit, ANC is an important venue for identifying HIV+ women. According to PEPFAR APR15 data, 96% of pregnant women who attend ANC visits know their status, and 93% of HIV+ women received ARVs. Eighty-six percent of all HIV+ women initiate ART at the ANC. HIV prevalence in ANC is 8% nationally. Male partner testing reached 34% in SAPR15 but it varies widely across the country. EID and linkage to treatment, retention of HIV positive women in care and appropriate utilization of viral load monitoring are critical challenges for the PMTCT portfolio, as confirmed by our SIMS data, and these areas will be a focus for PEPFAR partners in FY17. PEPFAR will continue to support the national quality improvement strategy for PMTCT that now also includes early retention and viral load.

In FY15, 64% of exposed infants in PEPFAR sites received HIV testing in the first twelve months of life. Challenges are related to quality of samples, a fragile logistics system with lengthy turnaround times and gaps in the instrument maintenance program. Near the end of 2015, laboratories faced shortages of polymerase chain reaction (PCR) EID reagents and PCR EID test kits (Abbott Laboratory) as support for their procurement transitioned from UNITAID to the GFTAM. The situation was resolved by emergency procurement through PEPFAR. However, future stock shortages are expected due to the central bank of Mozambique holding up the movement of funds from Quimofar (Abbott local agent) to Abbott in Germany.

[18] Mozambique DHS 2011

PEPFAR is closely collaborating with MISAU to overcome these difficulties with a coordinated multifocal approach that addresses program and laboratory challenges. Key strategies include training health providers on quality sample collection, training lab technicians on use of new technology (Abbott and Roche), revising and strengthening the laboratory forecasting and logistic system, improving sample transport and supporting rapid return of results to health facilities and caregivers. In addition, PEPFAR funded community workers will increase coordination with health facility to maintain lists of children needing follow up.

The most critical challenge for PMTCT is retention on treatment among pregnant and lactating women along the entirety of the care cascade. Retention drops from 58% to 56% after 6 months and 12 months respectively. Focused interventions to improve retention include intensified use of an individualized, longitudinal case management strategy utilizing mentor mothers and health educators to prevent loss to follow-up (with an intensive focus on the immediate diagnosis and ART initiation phase) and implementation of mother2mother support groups. Community-based interventions will be implemented to improve follow up for mother-baby pairs, increase male involvement and address the prevention and reduction of GBV including PEP, legal and psycho-social support.

4.5 HIV Testing and Counseling (HTC)

The primary objective of the HTC program is to identify HIV positive individuals to achieve treatment targets. Secondary objectives include increasing identification of men who are HIV positive (as they are currently underrepresented in HIV care), ensuring linkage to care, and maintaining test quality.

PEPFAR-Mozambique's strategy focuses on high-volume, high-yield, scalable modalities.

- PEPFAR seeks to fully implement the MISAU guideline of universal testing in specific high-yield clinical settings including inpatient, TB services, and emergency. Symptom-based HIV testing will be offered in other settings such as triage and well clinic. Focused implementation science will help to identify the highest yield sub-settings and ensure these are fully covered by PICT. PEPFAR-Mozambique will begin co-located VCT, the highest yield high-volume modality, in all feasible sites in scale-up districts not already covered. Co-located VCT is also a relatively successful modality for identifying male HIV positive individuals (45% of tested are male vs 31% in PICT).
- PEPFAR-Mozambique will work with MISAU to determine whether expansion of HIV testing to presumptive TB cases (in addition to confirmed cases) is indicated.
- PEPFAR-Mozambique will scale up index-case testing and KP outreach, which are both high yield modalities, with testing occurring in both facility-based and community settings. Index-case testing will also be used as an opportunity to identify sero-discordant partners for reinforcement of treatment implementation and messaging.
- The PEPFAR-Mozambique Gender analysis (2016) emphasizes the need to test men who are at risk of becoming infected with HIV. In addition to existing VCT, MSM, prisoner, and VMMC testing programs used to identify HIV-positive males, PEPFAR-Mozambique will further explore workplace testing including miners, testing of ill persons presenting to traditional healers, and incentivized peer referral for key populations as new or relatively underutilized testing modalities in Mozambique.

SIMS data indicate that linkages are a weakness in the HTC program. Strategies to ensure newly diagnosed PLHIV are enrolled in care include: reinforcement of post-test counseling, intensified coverage of peer educators to accompany clients and act as case managers, active referral into care whereby the counselor themselves escort newly diagnosed patients into care services, introduction of real-time defaulter tracing system to find and re-integrate diagnosed PLHIV into care services, expansion of the HTC one-stop model, where the patient file is opened at the point of testing, prioritization of newly diagnosed PLHIV in the (usually long) lines to receive care services and revision of HTC M&E tools to incorporate linkage measurement.

SIMS also highlights HIV testing quality as a programmatic weakness. To improve rapid HIV testing COP16 will: Disseminate the national testing quality improvement guidelines in which the HIV rapid testing minimum standards are defined; provide HCW refresher training and ensure certification to perform HIV testing; ensure that all facilities that receive the standardized specimen panel respond accordingly in collaboration with the INS, DPS, and implementing partners. Activities to assure quality of testing including use of dried tube specimens for external quality assessment (EQA), logbooks at service delivery sites, and provision of basic resources to maintain high quality testing will continue. Supportive supervision will continue in collaboration with central and provincial health authorities. PEPFAR-Mozambique is also working with the MISAU to explore revision of the national HIV rapid testing algorithm to introduce a confirmatory test prior to initiating treatment to minimize the possibilities of false positives, particularly as T&S is rolled out.

The HTC program will leverage the DREAMS Initiative to ensure any AGYW who are identified as HIV-positive receive appropriate services. Through ongoing activities initiated through ACT, strategies will be pursued to increase pediatric testing and case identification by systematically performing targeted case-finding in children and adolescents in high-yield sectors of the health system in high HIV prevalence geographic settings and by collaborating closely with the OVC program.

With the ACT Initiative, strategies were developed to increase pediatric testing and case identification by systematically performing targeted case-finding in children and adolescents in high-yield sectors of the health system in high HIV prevalence geographic settings. COP16 will continue to support these strategies. EID will be strengthened, and training in presumptive diagnosis and treatment are ongoing. In addition, routine opt-out testing (ROOT) of high-risk groups (inpatients, TB patients, malnourished children, OVC, and family members of PLHIV) and symptom-based PICT will expand. COP16 will also intensify youth counseling and testing at adolescent friendly health units and improve detection of poor adherence and treatment failure via strengthening clinical usage of viral load monitoring.

The National HTC guidelines were finalized during COP15 and dissemination will intensify during COP16. Guidelines include new strategies to target HTC to increase case finding, improve HIV testing quality and strengthen linkages from HIV testing into care services.

4.6 Facility and Community-Based Care and Support

A comprehensive set of interventions to ensure the bidirectional linkages between facilities and communities is critical to decrease stigma, enhance patient detection, and improve patient retention and adherence. The community interventions framework will continue to implement client-oriented practices that improve the interaction between community and health systems to accelerate progress across the continuum of care.

For the first 90, the creation of an enabling environment for uptake of HIV testing and subsequently to ensure linkage to care and treatment services will be emphasized. Specific interventions include the promotion and implementation of index case testing for HIV and TB patients in the community, the expansion of male engagement to promote uptake of HIV testing including awareness for partner testing and ART initiation, and the use of community dialogues facilitated by PLHIV and local community radios to broadcast key HIV prevention and adherence related messages.

For the second 90, interventions will aim to facilitate enrolment of diagnosed patients into care and rapid ART initiation and to expand the use of health educators that work both in the facility and in the community to follow patients through to care initiation.

For the third 90, activities that support medication adherence and retention in care interventions will be implemented both at the facility and community. Interventions may include the use of the M-health platform (e.g. using SMS or phone to remind patients about follow up appointments and other key messages). Using PLHIV as champions and advocates is critical to ensure successful implementation of interventions. Different models of peer PLHIV support will be used, including community adherence support groups (Grupos de Apoio a Adesão Comunitária - GAAC), health educators, Mentor Mothers, and Mother to Mothers groups, adolescent and pediatric support groups,and *Pais e Cuidadores* (Parents and Caregivers). Additional interventions will include involving community health agents, health educators, Community Health Workers (Agentes Polivalentes Elementares - APEs), traditional healers, traditional birth attendants, and community leaders to support adherence and retention. A combination of interventions including community drug distribution and enhanced treatment literacy programs for those newly on treatment will be used to further address retention challenges.

4.7. TB/HIV

The twin epidemics of TB and HIV have consistently resulted in high TB/HIV co-infection rates (52%) and high HIV associated mortality in TB/HIV co-infected patients (134/100,000 compared to 67/100,000 for HIV negative TB patients). Provider initiated testing and counseling for TB patients and ART initiation has been steadily improving. At a national level in APR 15, 98% of all TB patients had documented HIV status in the TB register and 87% of all HIV-infected TB patients were initiated on ART (up from 95% and 68% in APR13 respectively).

Currently, TB case detection in Mozambique is at 39%. TB screening for HIV patients is not consistently implemented, and tools for monitoring completion of the TB Intensified Case Finding

(ICF) cascade for PLHIV are limited. PEPFAR-Mozambique will provide TA to improve case detection through expansion of TB screening and case finding in PMTCT, antenatal clinics, HTC settings, ART settings, and for in-patients, for adults and children in scale-up districts. To increase TB case detection, beginning in COP16 integrated TB screening and HIV testing will be offered to TB contacts and presumptive TB patients. Cough officers who conduct routine screening for patients will be expanded. Additionally, support will be provided to expand health workers' ability to conduct TB surveillance in all high yield districts. Isoniazid preventive therapy (IPT), infection control measures, and cotrimoxazole for TB/HIV patients will continue to be provided in all scale-up districts. A national TB survey supported by GFTAM is scheduled for 2016 will provide a better understanding of TB rates in the country.

Challenges identified in SIMS visits were the TB diagnostic evaluation cascade; IPT; and facility linkage to community. SIMS analysis have been shared and discussed with the provincial directorates and partners and follow up visits have been conducted in problematic clinics with intensified TA to targeted sites.

In 2015 MISAU adopted the new WHO recording and reporting forms country-wide incorporating sex and age disaggregation. Clinical implementing partners (IP)have ensured that data is used to inform the design of gender-specific approaches in service delivery. In addition, this work will be done both at the community and facility levels to ensure that TB is not seen as a man's disease and infected women are not stigmatized.

Increased ART coverage to 100% for co-infected military members will be reached through mobile treatment units and reduced lost-to-follow up through delivery of GeneXpert MTB/RIF diagnostic capabilities at military medical sites.

PEPFAR partners will support monthly meeting between TB nurse/supervisor and pharmacy personnel to validate patient's information and stock management.

4.8 Adult Care and Treatment

The Mozambique ART program has scaled up rapidly since the implementation of the national accelerated response to HIV in 2013, in addition to the adoption of universal ART for pregnant women and national roll out of tenofovir based 1st line regimens. Treatment coverage has been steadily increasing, with adult coverage reaching 49% by December 2015.

Prevailing challenges include low adult ART retention rates of 67% by 12 months on treatment, which is worse among adolescents and pregnant women; low male participation (at APR15 30% of patients on ART were men) and slow roll-out of routine viral load (VL) monitoring.

PEPFAR IPs will continue to support the standard package of services defined in COP15 using a tiered approach, with the highest level of support in scale-up facilities, decreased support and visit-frequency (4 visits/year) in sustained facilities, and a minimal package of support including 2 visits/year, QI support and central TA in central-support facilities (See Section 5.1 and 5.2).

The following innovative approaches will be implemented in all scale-up districts to improve ART initiation and treatment: strengthening linkages between community and health facilities through health educator outreach activities; expansion of quarterly patient file reviews to assess ART eligibility; implementing strategies to increase male involvement; expansion of One-Stop-Shop models, early initiation of ART, diagnosis and treatment of ART related side effects; disclosure support; stigma reduction; nutritional support;

In addition, core interventions to improve retention and VL suppression will be implemented, including enhanced ART adherence support with particular focus on patients with detectable viral load; facility patient flow improvements; text message reminders and a tiered defaulter tracing cascade; preventive home visits for high-risk patients; and development of sample based approach to lost-to-follow-up (LTFU).

The results of the PEPFAR Gender Analysis have been incorporated in planning the adult treatment portfolio by specifically including districts with high estimated rates of HIV among AGYW to initiate implementation of T&S including for men during COP16. Additional efforts will be made to provide post GBV care services in scale up districts as the health facility coverage of these services is currently less than 20%).

Test and Start Implementation

In March 2016, MISAU committed to phased implementation of T&S with national implementation by FY18. Please see Appendix D for a summary of the phased implementation timeline and coverage).
Key interventions will support the phased implementation of T&S, including:

- Viral Load. Advance from Phase 1 VL implementation (focused on pregnant and breastfeeding women, children <5 years, and suspected treatment failure) to Phase 2 VL implementation (routine VL monitoring for all ART patients). Additional support to clinicians and decentralization of second-line drug committees is key to ensure appropriate management of ARV treatment failure cases. COP16 support includes training and mentorship, and infrastructure renovations specific to T&S and viral load implementation. Drug distribution systems will be strengthened to ensure timely delivery of ARV drugs to health facilities and patients.

- Implementation of alternative service delivery models, including 3-month drug distribution and 6-month clinic visits for stable adult patients (3-month clinic visits for stable children over 5), enhanced case-management and individual follow up at community level during the first 6-months on ART. Mozambique will pilot ARV distribution to non-ART sites to further decongest clinics and implement pharmacy-based electronic patient management systems to improve patient flow and LTFU tracking. Mozambique will also prioritize male-focused interventions in T&S districts (e.g., example extending clinic hours, male peer outreach).

- PEPFAR will also support minor infrastructure changes to accommodate increased patient load expected from T&S roll out and will include enhancing physical space to accommodate high throughput or point-of-care (POC) VL machines, improved lab supply chain management, and a focus on improving overall lab efficiency, with the goal of minimizing lost samples, ensuring quality results, and improving lab turnaround times. Options for improving sample transport in Mozambique will be reviewed with the goal of establishing a cost-effective and reliable sample transport system.

- Tools for assessing readiness for T&S, evaluating the qualitative aspects of implementation, and assessing impact will be developed prior to implementation of Phase 1.

4.9 Pediatric Care and Treatment

As of 2015, Mozambique's pediatric ART eligibility criteria include universal coverage for all children <5, coverage for children 5-14 with CD4<500 or WHO stage III/IV, and presumptive diagnosis on exposed infants. ISAU is currently considering approval and adoption of LPV/r for all children <3 regardless of pediatric exposure, with PEPFAR support for pilots of LPV/r pellets.

At present, MISAU is planning to roll-out pediatric T&S in concert with implementation for the adult population, contingent on availability of adequate support for disclosure, adherence and retention, especially for adolescents. Additionally, MISAU is considering alternative service delivery models for pediatric populations, including multi-month scripting and adoption of new pediatric formulation for lopinavir/ritonavir. PEPFAR will support effective implementation of MISAU guidelines on 3-month clinical visits for stable HIV+ children over 5 years of age. A pediatric loss to follow up analysis (of both pre-ART and ART patients) and a back-to-treatment campaign will be conducted in T&S districts.

SIMS data show that pediatric ART monitoring, adolescent support services, and pediatric facility referral to community care and support services need improvement. PEPFAR-Mozambique's Health Educator Strategy will provide case management services, including referral and disclosure support. This strategy will be scaled up in FY17. PEPFAR will support renovation or prefab construction for two new youth-friendly health clinics (Serviços Amigáveis Para Adolescentes e Jovens - SAAJs) per province in T&S districts in FY17. Substantial expansion of the VL platform is planned for FY17 (see 6ection for additional information). SIMS also showed a handful of stock-outs of ARVs and cotrimoxizole; this will continue to be monitored and will be addressed through strengthening of the logistics and transportation system.

Approximately 29% of Mozambican girls experience sexual debut before age 15 and that over half of the sexual violence cases reported at Maputo Central Hospital are in children under 15. PEPFAR will continue to improve the quality and availability of GBV services in PEPFAR-supported sites including screening, care and treatment (including psychosocial support as well as post-exposure prophylaxis and emergency contraception).

PEPFAR-Mozambique continues to support the National Quality Improvement Strategy, which includes pediatric indicators.

4.10 Orphans and Vulnerable Children (OVC)

COP16 aligns the OVC portfolio with the care and treatment scale-up districts and improved targeting to reach OVC directly affected and infected with HIV.

Key interventions include: a) rotation of OVC home visitors to the nearest ART sites to identify OVCs of PLHIV, b) index case testing of OVC with malnutrition, cared for elders, school absentees, children of CSW and PLHIV, and their family members (to identify PLHIV), and c) case management for positive pregnant and lactating women on B+ and exposed babies to enroll OVC. Emphasis will continue to be on a family-centered socio-economic care and support model and improved coordination/collaboration with ART sites, including pediatrics and PMTCT, through establishment of MOUs to strengthen community facility linkages and bi-directional referrals.

Core interventions include socio-economic activities critical to prevent and mitigate the impact of HIV/AIDS on children and ensuring their most basic needs are met. Near-core activities which cannot yet be undertaken by other partners or government include activities that provide for a sustainable social infrastructure (i.e. social welfare cadres, Community Committees, youth clubs and safe spaces)

A strength-based case management approach ensures that the health needs of OVCs are addressed through building health and nutrition knowledge and skills among caregivers, facilitating access to HTC, and linkages to ART. Through ACT, community-based (CBO) and faith-based (FBO) organizations proactively identify children for testing and treatment and refer those identified in ART sites to community-based social services. Early childhood development (ECD) platforms address developmental delays experienced by children infected, exposed to and affected by HIV, by linking with and targeting mothers in PMTCT programs. Stable environments will be nurtured through economic strengthening focused on the expansion of savings groups plus parenting, access to social protection to reduce economic instability, protecting adolescents from GBV, and ensuring victims receive proper counseling and care. A special emphasis in conjunction with DREAMS will be focused on keeping adolescent girls HIV-free, using evidence-based interventions through education, linkages to sexual reproductive health and HTC, psychosocial support, socio-economic package, and parenting caregiver programs with emphasis on adult/child communication. Subgroups of girls at high risk for HIV infection will be pro-actively identified using community, church and traditional leaders. Cross-referral mechanisms for these girls will be strengthened with relevant sites.

Activities will be implemented in 78 scale-up districts within the catchment areas of ART sites and in coordination with other HIV stakeholders and MGCAS. COP15 concluded implementation in sustained districts focusing on strengthening the community based response. Transition from those areas had already been planned as part of the mechanisms close out.

Above site activities include support to MGCAS to provide decentralized Social Action Technician and Infant Educator courses in partnership with MISAU training Institutes, data collection tools and systems designs for both GRM and CS, FBO/CBOs capacity building including community based structures working with OVC, and advocating for social policy for child and social welfare. Resources will be set aside to evaluate OVC interventions through outcomes and impact studies.

5.0 PROGRAM ACTIVITIES IN SUSTAINED SUPPORT LOCATIONS AND POPULATIONS

5.1 Package of services in sustained support locations and populations

As part of the increased focus for PEPFAR-Mozambique, 195 health facilities were identified as sustained response sites which fall outside of the 78 scale-up districts. All sites in sustained districts with ≥100 ART patients are included as sustained sites. Those with less than 100 ART, B+, or HTC positive patients were categorized as either central-support or non-support.

The main difference between the scale-up package and sustained response package is based on passive enrollment into treatment which is projected at 10% growth in FY16 and 5% in FY17. By FY17, a total of 77,939 out of an estimated 126,363 PLHIV will be on ART, with a treatment coverage of 62% in these sites.

Sustained sites will receive clinical mentorship, QI support, and the full of package of PMTCT services. These sites will implement national treatment guidelines and will not start implementation of T&S until FY18. Some of these include large, high-volume sites with greater than 1,500 ART patients, which therefore merit a robust package and interventions focused on adult and pediatric ART retention and quality services. There will be no demand creation activities in sustained districts, with less frequent visits from PEPFAR implementing partners. (4 visits/year for sustained sites vs 6-8 visits/year for scale-up sites). Details of the package of services across technical areas are provided in Table 5.1.1 Package of Services by Health Facility Category

Table 5.1.1: Package of Services by Health Facility Category

District Category	Saturation and Aggressive Scale-up	Sustained or Attained	
Health Facility Category	**Scale-Up**	**Sustained**	**Central-support**
Visit Frequency	≥6/year	≥4/year	2/year
Site support approach	QI, Clinical mentoring and supportive supervision (HTC, pre-ART, T&S, PMTCT, TB/HIV)	QI, Clinical mentoring and supportive supervision	QI-lite Support
Education/ Demand Creation	Treatment literacy (Adult and Peds ART, PHDP, TB/HIV); Demand creation/education for VL and T&S (where applicable); Stigma reduction interventions; Community/facility mobilization; Roll-out of PMTCT and pediatric national communication strategies	Treatment literacy, Stigma reduction interventions	
HTC	Index-case based testing; VCT expansion; pilots for identification of male positives (traditional healers, incentivized peer referral) under PEPFAR guidance; KP facility-based testing; PICT optimization; as needed support for implementation of GRM HTC guidelines; quality assurance support; improvement of M&E processes, e.g. age/sex disaggregation; national level commodity support	KP facility-based testing in select hotspots; PICT optimization; as needed support for implementation of GRM HTC guidelines; quality assurance support; improvement of M&E processes, e.g. age/sex disaggregation; national level commodity support	National-level commodity support; transition planning for ongoing investments, e.g. VCT
Pre-ART/ Care	Quarterly review of pre-ART patient files to identify ART eligible patients; Clinical mentorship for PHDP, STI diagnosis, cervical CA screening, OI diagnosis and treatment, FP/HIV, GBV, NACS	Clinical mentorship, PHDP	
ART	Clinical mentoring; Support for implementation of new guidelines CD4<500 and T & S (trainings, job aids, tools);; one clinic visit every 6-months and 3-month drug-pick up schedule for stable patients; Warm line; last-mile/specimen transport support; GBV; NACS; PHDP/OI management; National level commodity support	Support for new guidelines; last-mile/specimen transport support; Clinical mentoring on treatment, PHDP, OI management Warm line National-level commodity support; Last-mile/specimen transport;	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite
Retention and adherence support	M-health communication to patients; GAAC support and expansion; Preventive home visits for patients high risk for LTFU; Community tracing of LTFU patients;	GAAC, Mentor mothers and pilot of M2M groups	GAAC
PMTCT	Clinical mentoring (C&T; partner testing; quality of testing; B+; EID; TB/HIV; CTX; IPT malaria; syphilis testing; cervical cancer screening; FP/HIV; GBV; NACS; retention; VL testing; early identification of TF suspects); PHDP package; syphilis tests; Mentor Mothers / Health Educators and M2M groups for retention support; National-level commodity support; Last-mile /specimen transport; Warm line	Clinical mentoring; PHDP package; syphilis tests; Mentor Mothers/ Health Educators and M2M groups for retention support; OI management; National-level commodity support; Last-mile /specimen transport; Warm line	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite

District Category	Saturation and Aggressive Scale-up	Sustained or Attained	
Pediatric/ Adolescent Care & Treatment	Clinical mentoring (focus on TB & malnutrition diagnosis/treatment, CTX; IPT TB, GBV; VL monitoring & early identification of TF suspects); Health Educators for intensive case management, including disclosure & retention support (1:25 ratio); Health Educators for case identification in high yield settings; Monthly teen clubs in all priority districts; Provincial pediatric teams; National-level commodity support; Last-mile/specimen transport; Warm line	Clinical mentoring; OI management; retention & adherence, National-level commodity support; Last-mile /specimen transport; Warm line	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite
TB/HIV	Clinical mentoring, Implementation of 3I's (Intensified case finding, Infection control, and IPT); Early ART for TB/HIV patients through one-stop shops; Integrated outreach services (HIV testing & TB screening); Expanded contact tracing; Systematic TB screening/HIV testing in high risk groups (miners, prisoners);	Clinical mentorship for implementation of 3I's and early ART for TB/HIV patients	Through QI-lite
KP	Training and M&E support for KP friendly clinics; Medication-assisted therapy pilot for PWID under PEPFAR guidance; Roll-out of new National Guidelines for Care and Treatment of MSM and CSW's	Training and M&E support for KP friendly clinics in select hotspots	
OVC	Full OVC package with linkages to health facility. See Section 4.10 for additional details.	N/A	N/A
Lab	HIV- testing quality assurance; Support lab infrastructure for VL/EID/TB dx and address bottlenecks Continued baseline CD4 and biannual CD4 support where VL not available; Continued support for Cr and Hgb based on treatment regimen; Support of specimen referral, results reporting, and lab supply chain; Support for decentralized EQA	HIV-testing QA; Hgb, Cr, and biannual CD4 where VL not available; Specimen-referral, results-reporting, and lab supply chain-support	Specimen-referral, results-reporting, and lab supply chain-support
SI	Support for routine M&E activities (data clerks, registers, training, and supervision); Electronic patient tracking system support for all ART facilities with > 500 patients; Develop a module for monitoring HIV exposed children	Support for routine M&E activities (data clerks, registers, training, & supervision) Electronic patient tracking system support for all ART facilities with > 500 patients	Procurement of registers and clinical forms
Routine M&E/ Evaluation of new strategies	Benefit of VCT expansion?; Qualitative assessment of male-friendly treatment service provision; Evaluate the root causes of low retention among PWBF and design strategies to address identified issues; Sample-based LTFU analysis; Routine data-collection on effectiveness of retention strategies (GAACs, APES, health educators, mentor mother strategy); Tablet based supervision and cQI		

Table 5.1.2 Additional Activities and Services in Test and Start Districts

Category	Activity
Visit Frequency	≥8/year
Site support approach	• QI, Clinical mentoring and supportive supervision • Pre- and post-implementation assessment of selected sites
Demand Creation	• Demand creation/education for T&S • Male-engagement strategy implementation
HTC	• Training and development of materials for change in pre- and post-test counseling and linkage procedures to reflect new T&S guidelines • Increased focus on test quality including re-testing due to higher stakes
Pre-ART/ Care	• Community tracing of previous LTFU pre-ART patients
ART	• Support for implementation of new guidelines for T&S (trainings, job aids, tools) • Improved service delivery models to decongest clinics (6 month clinic appointments for all stable patients/quarterly drug pick-ups) • Expansion of electronic pharmacy patient management system •
Retention and adherence support	• Pilots of alternative ART distribution models (e.g. non-ART clinics) • Continued pilot of mobile health clinics to support ART expansion
Pediatric/ Adolescent Care & Treatment	• Support for implementation of new guidelines for T & S (trainings, job aids, tools) • Pilot of quarterly visits for stable older children & adolescents • Adherence counseling prior to initiation of ART for adolescents • Renovations / pre-fab units for SAAJs and MCH one-stop-shop clinics (2 each per Phase 1 T&S district) • Pediatric loss to follow up analysis (of both pre-ART and ART patients) combined with a back-to-treatment campaign
TB/HIV	• Piloting HIV-testing in presumptive TB patients • Enhanced support for TB diagnosis among PLHIV
Lab	• Focused lab strengthening, including infrastructure, staffing, and specimen-referral improvements to accompany implementation of VL Phase 2 implementation (routine VL monitoring)
SI / Routine M&E	• Expansion of barcode-based electronic pharmacy patient management system for monitoring retention at high-volume sites (>2000 pts) • Pilot POC EPTS systems at very high-volume sites (>5000 pts) • Biometrics and/or unique IDs in facilities or testing sites to improve patient identification • Integrated Health Information System (HIS) that links people across the clinical cascade and from different service entry points
Evaluation of new strategies	• Process evaluation of Test and Start implementation and transition to differential service delivery mode Implementation of repeat-testing of HIV+ clients before starting ART • Yield of intensified contact tracing/ universal screening for presumptive TB, TB contacts, miners & prisoners • Assessment of alternative ART distribution points

Table 5.1.3 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group	**Expected result APR 16**	**Expected result APR 17**	**Percent increase (decrease)**
HIV testing in PMTCT sites	**123,981**	**281,646**	**127%**
HTS (only maintenance ART sites in FY 17)	***HTC_TST***		
Current on ART	**89,789**	**114,531**	**28%**
OVC	***0***	**0**	**-**

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

PEPFAR-Mozambique has identified 181 health facilities as central support sites. Of the 38 sites scheduled to for transition this fiscal year (per COP15 agreement), six have increased in patient volume to over 365 individuals on ART and 760 HIV positive patients overall. These sites will receive Sustained Support. The remaining 32 will continue to be categorized as central support. In addition there are 10 sites which will no longer receive direct PEPFAR support in COP16. The USG recently signed a G2G agreement with Mozambique, which creates new opportunities to expand direct support to MISAU that will facilitate this transition.

Centrally-supported sites will continue to receive two visits/year from IP's for mentoring and supervision, national level commodity support for all key HIV commodities, last mile support (including RTK, ART, and lab commodities), support for specimen referral and results reporting, and QI "lite" support.

6.0 PROGRAM SUPPORT NECESSARY TO ACHIEVE SUSTAINED EPIDEMIC CONTROL

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Mozambique participated in the Systems Budget and Optimization Review (SBOR), which was a thorough review of its systems investment portfolio. Through this process PEPFAR-Mozambique identified three systems gaps critical to achieving 90-90-90 and sustained epidemic control. These are supply chain, human resources for health and strategic information. The Mozambican supply chain system has limited capacity (human, technical and physical), which will be further stretched by the rollout of test and start. Also, Mozambique has one of the lowest ratios of HRH/population in the region and, in spite of significant improvements in data availability (EPTS coverage has increased nearly threefold from 127 health facilities 2012 to 365 facilities in 2015.), information challenges are still significant barriers to achieving 90-90-90.

Sustaining investments in supply chain, strategic information and human resources for health will support the successful implementation of test and start, as well as roll-out of new service delivery models, and, ultimately, epidemic control.

For COP16, investment in these three critical systems will allow the program to;

- Support Mozambique to build an integrated and efficient supply chain system capable of sustaining the throughput necessary to implement test and start and reaching 90/90/90.
- Support training of key cadres of HRH critical to reaching 90/90/90, including public health logisticians, pharmacy technicians and laboratory technicians, as well as supporting HRIS expansion to improve efficiencies in allocation of human resources to high burden districts/sites.
- Extend strategic information investments critical to improving patient quality of care (e.g. EPTS) rapidly to all DREAMS and ACT sites, as well as T&S districts.

In addition to investing in these three key systems, PEPFAR Mozambique conducted a prioritization exercise, ranking in order of importance the investments which are critical to sustainability in financing, governance, institutional development and laboratory. Decisions about those investments are reflected in the tables below.

Table 6.1.1 Key Programmatic Gap #1: Inadequate **supply chain** to support program growth						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Strain on warehousing space and quality given the increased commodity need to achieve 90-90-90, test and start, and viral load scale-up.	1. Warehouse and cold chain storage space is sufficient to manage the increase in volume from treatment, EID, and viral load scale-up 2. Less than 3% expiries at central warehouses 3. Central warehouse inventory accuracy greater than 90%	Secure central warehouse availability, strengthen controls and improve quality of warehousing practices and distribution systems in central and provincial warehouses for tests, treatment, and lab commodities, and support changes to warehouse policies and procedures required to manage increased volume.	OHSS	$1,850,000	GHSC	8. Commodity Security and Supply Chain (3.59)
		Support the development and pilot implementation of an intermediate warehouse strategy aligned with the PELF and Global Fund warehouse rehabilitation efforts.	OHSS	$1,200,000	GHSC	8. Commodity Security and Supply Chain (3.59)
More real-time logistics data availability and visibility required for appropriate management of commodities and quality forecasting and quantification with multi-month scripting and 90-90-90 program growth.	1. Human resources are adequate to submit and analyze data using appropriate information systems 2. Greater than 70% forecast accuracy 3. More than 80% of logistics reports are complete and submitted on time	Support activities and build capacity in MoH staff in quantification, forecasting, and supply planning including annual quantifications and quarterly supply plan updates and donor coordination (e.g. Global Fund) for medicines, tests, and lab commodities.	OHSS	$750,000	GHSC	8. Commodity Security and Supply Chain (3.59)
		Develop LMIS strategy and coordinated approach while continuing to maintain the use of existing LMIS including modifications required to align with service delivery model changes.	OHSS	$1,650,000	GHSC	8. Commodity Security and Supply Chain (3.59)
		Support the development of supply chain staff to manage, analyze, and make decisions based on logistics data for tests, treatment, and lab commodities including training, mentoring, and facilitating.	OHSS	$550,000	GHSC	8. Commodity Security and Supply Chain (3.59)
Table 6.1.1 Key Programmatic Gap #1: Inadequate supply chain to support program growth (CONTINUED)						
The current supply chain is slow, fragmented, and inefficient, which is inadequate to appropriately support the needs of test and start, multi-month scripting, and 90-90-90.	1. Supply chain design is patient-focused 2. ARV tracer stock out rate maintained at 5% or below despite growth in treatment sites and commodity need 3. Appropriate supply chain knowledge and expertise exists throughout the supply chain 4. Lab specific supply chain issues are addressed at the appropriate organizational units(s) in MISAU	Provide commodity procurement services, support commodity importation/customs clearance, and provide lab commodity delivery direct to the labs.	OHSS	$1,300,000	GHSC	8. Commodity Security and Supply Chain (3.59)
		Strengthen lab logistics management through strategic integration of lab logistics activities within the MoH, development of the lab logistics system given viral load scale-up, coordinated lab supply plan, donor coordination, implementation of an electronic stock card at provincial and district labs, supportive supervision, data analysis, stock planning, and monitoring equipment downtime and maintenance.	OHSS	$1,400,000	GHSC	8. Commodity Security and Supply Chain (3.59)
		Strengthen last mile logistics through the design of systems approaches for medicine distribution, province and district supply chain management support and	OHSS	$1,400,000	GHSC	8. Commodity Security and Supply Chain (3.59)

		capacity building, technical assistance to implement lab sample logistics strategy, and coordinating the implementation of 3-month dispensing at the province and district level with the DPS and clinical implementing partners.				
		Support strategy development, planning, and implementation of supply chain human resources to take over and manage a streamlined supply chain.	OHSS	$450,000	GHSC	8. Commodity Security and Supply Chain (3.59)
		Develop and implement the second phase of a joint strategy with CMAM to reduce dependency on PEPFAR for operational support.	OHSS	$100,000	GHSC	8. Commodity Security and Supply Chain (3.59)
TOTAL				**10,650,000**		

Table 6.1.2 Key Programmatic Gap #2: Human Resources for Health- Insufficient quantities of adequately trained HRH distributed according to program expansion needs						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Insufficient and poorly deployed stock of HRH	90% of scale-up districts with a full staff complement Strengthened tracking of HRH (deployment, trainings (in-service, pre-service), thereby optimizing targeting of trainings and use of resources	Strengthening HR policy and guidance, relevant to scale up implementation through technical assistance and data analysis	OHSS	$1,200,000	JHPIEGO	Human resources for health (6.83)
		Support pre-service training of University level laboratory techs to increase quality of staff available in laboratory network to conduct testing	OHSS	$,120,000	TBD (ISCISA)	Human resources for health (6.83)
		CONTINUING Pre-service for additional technicians clinical officers currently enrolled	OHSS	$100,000	CCS	Human resources for health (6.83)
		Pre service training of 200 health technicians, MCH nurses and pharmacy technicians to increase health system capacity to adequately respond to HIV program scale up needs	OHSS	$520,000	FHI 360	Human resources for health (6.83)
		CONTINUING Pre-service for additional technicians in pharmacy, Lab, and MCH nursing, currently enrolled	OHSS	$362,814	ARIEL	Human resources for health (6.83)
		CONTINUING Pre-service for additional technicians in Lab currently enrolled	OHSS	$112,404	EGPAF	Human resources for health (6.83)
Lack of standardized approaches to in-service training	Use of standardized system to determine the competencies gap and guide in-service training Reduced spend on in-service training and increased use of distance learning/mentoring approaches	Support improvement of the MOHs in-service training including distance learning and distance mentoring activities, database integration and data analysis, as well as standardization and accreditation of courses and practicum sites.	OHSS	$800,000	JHPIEGO	Human resources for health (6.83)
		Support the harmonization of training package for KP, TB, and Health Educators	OHSS	$1,447,253	I-tech	Human resources for health (6.83)
		Coordinate the implementation of the National In-service training Strategy	OHSS	$150,000	MISAU	Human resources for health (6.83)
Lack of appropriately trained staff in key areas of lab necessary for T&S expansion	Trainings and standardized materials specific to address key T&S Lab strategies in place	Establish national trainers and mentors program for molecular diagnostics; implement peer to peer mentoring for molecular testing (EID/VL)	HLAB	$510,000	INS/ASCP	10. Lab (3.24)
		Roll out VL/EID training, competency assessment and supervision program	HLAB	$320,000	INS /MISAU/ ASCP/DPS	10. Lab (3.24)
		Training and certifications of LED microscope users and facility based maintenance program for	HVTB	$370,000	ASM	10. Lab (3.24)
TOTAL				**$ 5,892,471**		

Table 6.1.3 Key Programmatic Gap #3: Unavailability of Sufficient and Granular Enough **Strategic Information** to Support Effective HIV Programming						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
HMIS system does not contain sufficient, reliable, granular and disaggregated data for PEPFAR reporting and on-going geographical prioritization planning	National DHIS2 HMIS that can be used for planning the HIV response and reporting on the majority of PEPFAR indicators Interoperability of aggregate and individual-level systems Inclusion of community-level data in national HMIS Improved data quality	SISMA (national DHIS 2 aggregate reporting system) Roll-out and continued development and incorporation of additional modules	HVSI	$600,000	JEMBI (12681)	15. Performance Data (7.78)
		Open Health Information Exchange - HIE, and Master Facility List – MFL	HVSI	$600,000	JEMBI (12681)	15. Performance Data (7.78)
		Data quality management and harmonization efforts within SISMA for PEPFAR reporting	HVSI	$100,000	JEMBI (12681)	15. Performance Data (7.78)
		Adaptation of existing community-level data collection tools and processes (from the CAP, PCC, and CHASS projects)	HVSI	$100,000	Clinical Services System Strengthening (CHASS) (13022)	15. Performance Data (7.78)
		Data quality assessment (DQA internal and external)	HTXS, MTCT	$500,000	Ministry of Health	15. Performance Data
		Data quality assessment (DQA internal and external), TA for DQA to MISAU	HTXS, MTCT	$775,000	Mozambique Strategic Information Program (M-SIP) (17169)	15. Performance Data (7.78)
		Data quality improvement for routine program data	HTXS, MTCT	$450,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
ePTS that contains patient-level outcomes needed to determine progress on 90-90-90 targets is not scaled-up, linked to HMIS, or officially part of the flow of national health data	Functional, expanded, and integrated ePTS that allows tracking of patient-level outcomes and measurement of 90-90-90 targets Reduced turn-around times for EID / VL / Xpert MTB Rif / TB Culture	Developments and implementation for openMRS modules; TB, MCH, pharmacy	HTXS	$600,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		Requirements and development of a Pilot openMRS POC systems	HTXS	$350,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		openMRS Helpdesk and Troubleshooting	HTXS	$200,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		Laboratory Information System development	HTXS	$500,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		National Unique ID and Biometrics Development work	HVSI	$200,000	JEMBI (12681)	15. Performance Data
		Continuous Quality Improvement (CQI) Database	HTXS	$350,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		Optimizing HTC modalities, linkage to care and HTC data, including HTC openMRS development	HVCT	$200,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)

		Implement laboratory information systems (testing and logistics information) to facilitate timely results return and availability of data for M and E	HLAB	$1,130,000	APHL/UCSF	10. Lab (3.24)
		Development, Coordination and Evaluation of Integrated Health Information System (HIS) for Test and Start that links people from testing to different services and facilities from community to facility, and within facilities	HTXS, HVSI	$2,500,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)

Table 6.1.3 Key Programmatic Gap #3: Unavailability of Sufficient and Granular Enough Strategic Information to Support Effective HIV Programming (CONTINUED)						
Ongoing need for timely and accurate surveillance data to inform national HIV response planning and tracking progress towards epidemic control	Increased availability of up-to-date surveillance information that informs geographic and programmatic focus of the HIV response Increased access to viral load and EID testing for hard to reach areas. Increased capacity for routine surveillance.	Surveillance support activities (HDSS, mortality, IBBS, key pops mapping/size estimation, epi training, etc...)	HVSI	$600,000	INS (13784)	13. Epi and Health Data (4.70)
		ANC/PMTCT sentinel surveillance and transition to use of routine data	MTCT	$200,000	INS (13784)	13. Epi and Health Data (4.70)
		Viral load and drug resistance surveillance	HTXS, HVSI	$300,000	INS (13784)	13. Epi and Health Data (4.70)
		Combination Prevention Evaluation (CPE) platform/Chokwe HDSS	HVSI	$250,000	INS (13784)	13. Epi and Health Data (4.70)
		CISM HDSS Activities	HVSI	$240,000	CISM - Manhica Research Center (13661)	13. Epi and Health Data (4.70)
		Surveillance TA - Activities that are core to understanding the course of the HIV epidemic and all aspects of the HIV response	HVSI	$600,000	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
		PMTCT/ANC Surveillance Data Reporting System	HVSI	$500,000	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
		HIV Case-Based Surveillance Development and Implementation	HVSI	$300,000	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
		Mortality Vital Statistics Surveillance and SISROH	HVSI	$250,000	JEMBI (12681)	13. Epi and Health Data (4.70)
		INCAM Mortality Survey Preparations (implementation post-census)	HVSI	$500,000	Measure Evaluation IV (7328)	13. Epi and Health Data (4.70)
		Viral load and drug resistance surveillance commodities	HTXS, HVSI	$200,000	GHSCP (TBD)	13. Epi and Health Data (4.70)
		IMASIDA Report Translation, and Data Use and Report Writing Workshops	HVSI	$350,000	ICF DHS 7 (18121)	13. Epi and Health Data (4.70)
TOTAL				**$13,845,000**		

6.2 Critical Systems Investments for Achieving Priority Policies

PEPFAR-Mozambique identified HIV testing and re-testing, Viral Load, EID and GenXpert testing platform expansion, and clinical lab testing transition support as areas where rapid change in both policy and practice will be required to be successful at T&S. Most laboratory investments are incorporated into the supply chain, human resources, and strategic information system investments. However others, which are equally critical to implementation of T&S, are uniquely characterized in laboratory system development and do not fit clearly into the other system areas. Please see Table 6.2.1 for these other laboratory system investments.

Table 6.2.2 details systems investments to support differentiated and new service delivery models necessary to roll out T&S.

Table 6.2.1 Test and Start laboratory systems

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lab Systems essential for implementing T&S	WHO guideline for HIV testing services implemented	Support implementation or HIV re-testing policy before treatment initiation	HTC	$75,000	FIND	2. Policies and governance (1.43)
	Testing sites and personnel certified to conduct HIV rapid testing	Strengthen programmatic implementation and expansion of rapid test quality improvement initiative to all 77 scale up districts including certification, monitoring and evaluation systems	HLAB	$600,000	INS/MISAU/FIND	10. Lab (3.24)
	Quality management systems implemented in EID/VL, GeneXpert and CD4 labs; Reference laboratories accredited	Strengthen laboratories in continuous quality improvement and management systems. Provide support to assure PEPFAR supported laboratories meet quality standards.	HLAB	$1,310,000	INS/ASCP	10. Lab (3.24)
	Support implementation of national POC regulation	Quality PoCT available	HLAB	$150,000	APHL	10. Lab (3.24)
	Parallel PEPFAR lab supply chain integrated into MOH supply chain	Support policy and strategy for harmonization of lab supply chain by strengthening national quantification and maintain pipeline monitoring system at central laboratory department	OHSS	$220,000	APHL	8. Commodity Security and Supply Chain (3.59)
	Increased number of HIV testing sites participating in EQA and achieving 100 % pass rates on proficiency tests,	Increase coverage of national HIV rapid test EQA program and guide implementation of a decentralized EQA model	HLAB	$250,000	FIND	10. Lab (3.24)

	Reduced turn-around times for EID/VL/Xpert MTB Rif/TB Culture; increased quality of testing	Implement an integrated specimen referral system for EID, VL and TB samples; including district hubs to conduct barcode labelling, manage and track specimens and results	HLAB	$1,300,000	INS/ASM/APHL	10. Lab (3.24)
	Increased participation and performance in EQA	Expand coverage of National EQA program for CD4, EID/VL Xpert MTB Rif, TB smear microscopy and PoCT	HLAB	$450,000	ASM	10. Lab (3.24)
	Increased finding of TB/HIV co-infected patients and improved patient outcome and epidemic control including miners. Increased POCT contribution to routine surveillance.	Validate and implement laboratory component of multi tests POCT and other platforms for VL and TB in programmatic and community contexts.	HVTB	$500,000	FIND	10. Lab (3.24)
	Increased TB case finding by increased utilization of GeneXpert and implementation of Xpert MTB Rif algorithm for HIV positive TB suspects and MDR suspects and decreased morbidity and mortality of PLHIV	Establish capacity to test all patients initiating ART with enhanced TB diagnostic platforms. Increase utilization of GeneXpert	HVTB	$500,000	ASM/FIND/INS	10. Lab (3.24)
	Increase national capacity to conduct TB surveillance. Improve SI for national TB control program	Support laboratory component of National TB surveillance	HVTB	$100,000	INS	10. Lab (3.24)
	Increased utilization of GeneXpert and implementation of Xpert MTB Rif algorithm for HIV positive TB suspects and MDR suspects and decreased morbidity and mortality of PLHIV	Implement GxAlert to improve TB test reporting times and provide remote monitoring of Gene Xpert equipment errors and reagent consumption	HVTB	$120,000.00	ASM	10. Lab (3.24)
Lab Systems essential for implementing T&S	Improved sample quality. Decrease rejection rates. Decrease turnaround times of lab results.	Develop capacity for training for sample collection, storage and packaging for all health care staff involved in sample collection and referral (nurses, lab techs and *Técnicos de Medicina Geral* etc). Provide supplies.	HTXS/PDCS	$320,000	INS/ASM	10. Lab (3.24)
Lab Systems essential for implementing T&S	Strengthen laboratories in continuous quality improvement and management systems. Provide support to assure PEPFAR supported laboratories meet quality standards.	Quality management systems implemented in EID/VL, GeneXpert and CD4 labs; TB, HIV serology and CD4 Immunology Reference laboratories accredited	OHSS	$1,310,000	INS / ASCP	10. Lab (3.24)
Lab Systems essential for implementing T&S	Drug resistance capacity and BSL 3 Laboratory established at NPHRL	Strengthen Drug resistance testing and surveillance capacity and a BSL 3 laboratory at new NHPRL and provincial public health laboratories	HLAB	$850,000.00	INS	10. Lab (3.24)
TOTAL				**$8,055,000**		

Table 6.2.2 New and efficient **service delivery models**						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
	Strong and culturally appropriate community education and messaging on T&S, drafted through a national strategy has been designed, reproduced and disseminated through appropriate outlets including paper, community radio and theater.	Implement community messaging through radio, TV and print, (billboards, newspapers, posters), theater groups, etc. ($100,000 per province)	HTXS	$1,100,000	All Clinical IPs	10. Lab (3.24)
		Work with MOH to design and test demand creation materials through clinical and community-based approaches for roll-out with T&S/VL implementation $10,000,000 National-level JHPEIGO	HTXS	$1,000,000	Jhpiego	10. Lab (3.24)
		Develop HIV testing, pediatric care, and adult test demand creation strategy including materials/community messaging through radio, TV and print (billboards, newspapers, posters)	HTXS	$500,000	Johns Hopkins U.	10. Lab (3.24)
Lab Systems essential for implementing T&S	Guidelines following WHO T&S recommendations are followed and translated into appropriate and clear clinical guidance to the health facilities	Support for development and roll-out of new guidelines, regional and national-workshop to evaluate VL and T&S implementation, supportive supervision to implementing sites	HTXS, HBHC, PDTX, PDCS	$1,000,000	MOH DNSP	10. Lab (3.24)
	Testing is targeted to produce the most efficient yields and WHO guidance on re-testing in T&S pilot districts is implemented.	Pilot of presumptive TB HIV-testing, expanded household contact tracing (development of tools, staff training, CHW's) ($267,000 per partner)	HVTB HTXS	$800,000	FGH, ICAP, EGPAF	10. Lab (3.24)
Lab Systems essential for implementing T&S		Repeat testing on all HIV-positive persons (536,508 persons) out of those tested this year using UE of $4.04	HTXS	$2,200,000	Clinical IPs	10. Lab (3.24)
	Adequate space for pharmacy, laboratory specimen collection, testing and services is ensured for T&S expansion.	Pre-fab units/Minor renovations to accommodate increased space needs with implementation of T&S and **3-month drug** distribution (~$50,000 per unit)/Sites >2000 pts in ~ 50 in sites T &S districts)	HTXS	$2,500,000	Clinical IPs	10. Lab (3.24)
		Additional Pre-fab units/Minor renovations to expand availability for **TB/HIV integration** in sites in T&S districts without one-stop-shops (~$50,000 per site)	HVTB	$2,200,000	Clinical IPs	
		Renovation costs for **VL laboratories** (~$110,0000 per province)	HTXS	$1,210,000	Clinical IPs	10. Lab (3.24)
Lab Systems essential for implementing T&S		Establishment of physical space at district hubs for specimen referral/results reporting (~$35,000 per district - including printing, freezers, personnel)	HTXS	$1,260,000	Clinical IPs	10. Lab (3.24)

ePTS that contains patient-level outcomes needed to determine progress on 90-90-90 targets is not scaled-up, linked to HMIS, or officially part of the flow of national health data	At the end of year 1, information necessary to scaling up T&S, VL, and 3 mo. Drug distribution will be available to MOH and PEPFAR	Pilot use of peripheral non-ART health facilities for distribution of ART (pilot in test and start districts)	HTXS	$250,000	CHASS	
		Evaluation of test and start, VL, and 3-month drug-distribution implementation at the provincial level; Evaluation of enhanced integrated HIS approach to patient monitoring ($200,000 per province)	HTXS	$2,200,000	All clinical IPs	Commodity Security and Supply Chain (3.59)
		Exploration of alternative modes of ART distribution	HTXS	$650,000	CCS / EQUIP	Commodity Security and
		Implementation of electronic FILA for monitoring patient drug pick-ups/LTFU, with target implementation as all clinics with > 2000 ART patients in T&S districts (Computers/electronic device, database/ program, training of pharmacy staff) ($11,000 per site, ~ 74 sites)	HTXS	$814,000	Clinical IPs	Commodity Security and Supply Chain (3.59)
		Technology (open source computer, SIM card) to provide electronic results reporting	HTXS	$550,000	Manica, Sofala	15. Performance Data (7.78)
		Pilot expansion of integrated m-health systems including mobile platform for index-case testing, LTFU tracing, with linkage to HF tablet/EPTS (~$500,000 per partner)	HTXS	$3,500,000	All Clinical IPs	15. Performance Data (7.78)
		Technical assistance (short, medium, long term) for direct service delivery for differentiated models of treatment	HTXS	$500,000	EQUIP	
TOTAL				**$22,234,000**		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments							
Systems Category*	**Activity**	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Finance							
	Sustainable Finance Strategy: Continue to provide support to MOH and GOM to explore ways to sustainably increase funding for HIV. Support developing ways for MISAU to improve funding advocacy and to better allocate $ across program areas. Support innovations to link performance to funding at program and geographic levels. Increase levels of direct funding to Government and indigenous partner organizations to reduce costs.	4	20% increase in government funding for ~~HIV~~ programs	$500,000	OHSS	TBD	Strategic Investments, Efficiency and Sustainable Financing /Domestic Resource mobilization (2.5)
SUBTOTAL				**$500,000**			

Governance							
	Strengthen the technical capacity at National Laboratory of Drug Quality Control (NLDQC) to ensure commodities in the supply chain are of sufficient quality to achieve 90-90-90	1-4	NLDQC capacitated to perform quality tests on medicines in the country and ISO 17025 certified. Developed the Medicines Quality Assurance Regulation under the revised Medicines Act.	$100,000	OHSS	PQM	8. Commodity Security and Supply Chain (3.59)
	Improve national medicines policy, legislation, regulation, norms, and standards to ensure that MOH is procuring the most effective and least expensive ARV regimens and manages effective drug therapeutic committees	2-4	Pharmaceutical Policy and guidelines adapted to be in-line with WHO and SADC standards. Worked with Pharmaceutical Department (PD) in implementing new National Essential Medicines List (NEML), via training national and central staff on NEML, developed systems to monitor NEML and developed the regulations laid down in the revised Medicines Act. Creation of drug therapeutic committees at all provincial hospitals.	$100,000	OHSS	TBD-GH-02-2016-SIAPS follow on agreement	8. Commodity Security and Supply Chain (3.59)

HRH - Systems/Institutional Investments							
HR assessments and Information Systems	Better mapping of lay and community staff to inform decision around used to this person to improve retention Allocation and training of HR for HIV care and treatment improved based in key and current information in the districts MOH ownership in the use and quality assurance of information generated by the HRIS for decision making	1-4	Continue to support the development and expansion of the HRIS at the Provincial, District and Facility levels.	$900,000	OHSS	JHPIEGO / JEMBI?	7. Human resources for health (6.83)
		1-4	Strengthen management capacity of HIV epidemic control priority districts through support for maintenance of Human Resources Information Systems (e-CAF and SIFO) through the graduation pathway tool	$139,734	OHSS	FHI360	7. Human resources for health (6.83)
	Direct support to the training institutions to train currently employed nurses at mid-level to become superior level (University)	2	Increase of 25% of stock of superior nurses	$500,000	OHSS	TBD	7. Human resources for health (6.83)
	Capacity development for pharmacists and lab techs at provincial, and district levels	1,2,3	Increase of XX% of stock of lab techs and pharmacists	$250,000	OHSS	Various IP	7. Human resources for health (6.83)
	Strengthening Nursing career within context of HIV epidemic. Support the development of a national plan for reforming the career and practice of nursing. It includes support to the national nursing Department at MOH and the national training institute.	4	Updated nursing regulatory framework	$100,000	OHSS	Columbia University Mailman School of Public Health	7. Human resources for health (6.83)
	African Regulatory Council support to develop national nursing practice regulatory framework	4	Updated nursing regulatory framework	$100,000	OHSS	ARC HQ	7. Human resources for health (6.83)
	Support the pediatric department and residency training program at Maputo Central Hospital (MCH), to establish a center of excellence in pediatric care to ensure doctors and nurses are competent to care for children with HIV/TB.	4	Improve pediatric HIV, TB, and general care and through nurse and physician professional development and training	$250000	OHSS	JHPIEGO	7. Human resources for health (6.83)
SUBTOTAL				**$2,239,734.00**			
Inst & Org Development							
	DPS capacity building strategy. Continuation and expansion of NASTAD Abt/FHI work w DPSs and integration of USAID and CDC models. Fiscal capacity support of DPSs. Capacity Building Monitoring system (performance based). Implementing Partner monitoring and Pivot Monitoring work.	4	Establishment of direct funding agreements with all PEPFAR funded provinces	$1.400.000	OHSS	NASTAD/Abt	1. Planning and Coordination (7.33)
SUBTOTAL				**$1.400.000**			

Laboratory							
National Health System and Service Delivery	Update obsolete four-year laboratory university level pre-service training to include HIV related diagnostics, and support implementation of newly revised medium-level training	1-4	Adoption of updated national laboratory training curriculum across all health training institutions in Mozambique	$350,000	OHSS	ASCP / ITECH	7. Human resources for health (6.83)
National Health System and Service Delivery	Implement blood transfusion policy to guarantee safe blood supply and reduce transfusion related HIV transmission	1-4	Transfusion associated HIV infections averted. National Blood Service (SENASA) established in Maputo, Beira and Nampula. Electronic blood bank management system established at the National Reference Blood Center and provincial hospital blood banks. Quality management systems implemented.	$1,450,000	HMBL	MISAU BS / AABB / FIND	10. Lab (3.24)
Commodity Security and Supply Chain	Support training infrastructure and stock management systems at provincial warehouses and district deposits to improve storage and and maintain electronic stock card management system at provincial warehouses and district deposits distribution of lab commodities	4	Reduced losses of laboratory commodities due to expiry or poor storage	$585,000	OHSS	APHL	8. Commodity Security and Supply Chain (3.59)
SUBTOTAL				**$4,545,000**			
Strategic Information							
Monitoring and Evaluation	APR / SAPR / DATIM / MER indicator reporting	1,2,3,4	Devresults developed for site level reporting	$ 76,000	HVSI	DevResults (14597)	15. Performance Data (7.78)
Monitoring and Evaluation	Monitoring and evaluation staff for MISAU	4	Staff supported and MISAU M&E capacity strengthened	$ 200,000	HVSI	EGPAF TA (14789)	15. Performance Data (7.78)
Monitoring and Evaluation	Monitoring and evaluation staff for MISAU	4	Staff supported and MISAU M&E capacity strengthened	$ 200,000	HVSI	Clinical Services System Strengthening (CHASS) (13022)	15. Performance Data (7.78)
Monitoring and Evaluation	Support to DPS and DPC/DIS for M&E, including TA staff	4	Maintain and train Provincial IT support, Central Systems support.	$ 200,000	HVSI	JEMBI (12681)	15. Performance Data (7.78)
Monitoring and Evaluation	Pilot DATIM expansion to PEPFAR partners	4	Pilot implemented and findings delivered	$ 150,000	HVSI	CCS (13776)	15. Performance Data (7.78)
Monitoring and Evaluation	Triangulations of data sources, MOH coordination and HIS roll out	4	Reports provided	$ 250,000	HVSI	INS (13784)	15. Performance

							Data (7.78)
Monitoring and Evaluation	Human Resources Information System (HRIS) Integration	4	Systems integration with SIS-MA and harmonization with MFL allowing for interoperability of data systems significantly enhancing value of data	$ 100,000	HVSI	JEMBI (12681)	15. Performance Data (7.78)
Monitoring and Evaluation	Expansion of MGCAS Aggregate M&E system, development of dashboard and reports, strengthening capacity to use data	4	Platform, information architecture, dashboard tools, indicators all developed and capacity transferred to MGCAS	$ 400,000	HKID	Fortalecimento Dos Sistemas De Monitoria E Avaliação Do MGCAS (17259)	15. Performance Data (7.78)
Monitoring and Evaluation	OVC MER Level 2 Indicator Collection	1,2	Implemented evaluation for all OVC implementation partners	$ 600,000	HKID	Measure Evaluation IV (7328)	15. Performance Data (7.78)
Monitoring and Evaluation	Mozambique's Monitoring and Evaluation Mechanism and Services (MMEMS) platform.	1,2,4	Four annual PEPFAR routine data cleaning and reviews (Quarterly/SAPR/APR); and supported routine project monitoring visits for PEPFAR-funded activities	$ 500,000	HVSI	MMEMS (18104)	15. Performance Data (7.78)
Surveillance	INS Data Management Unit & GIS support	4	INS Data Management Unit set up and staff hired/seconded	$ 300,000	HVSI	INS (13784)	13. Epi and Health Data (4.70)
Surveillance	INS Data Management Unit & GIS support	4	INS Data Management Unit set up and support / TA staff hired / seconded. Includes modeling incidence, key pops.	$ 350,000	HVSI	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
Surveillance	HIV Modelling and forecasting, costing, feasibility of the first 90 target and strategy assessment, full costing of ART services, Test and Start modelling	1,2,3	Models and reports developed for Mozambique specifically to understand these key issues related to epidemic control in Mozambique	$ 240,000	HVSI	Palladium (14598)	13. Epi and Health Data (4.70)
SUBTOTAL				**$4.516.000**			

*Reference Appendix C for a list of activity types that fit in each category

7.0 STAFFING PLAN

In COP16, the PEPFAR interagency team reviewed its staffing profile to focus on strategic investments toward epidemic control within a limited M&O budget envelope. Agencies adjusted their CODB to reflect for expected increases in ICASS costs as well as projected increases in travel budgets to support SIMS implementation. In addition the team carefully reviewed staff budget code allocations to ensure that this data accurately captured time spend supporting various program areas.

All new/proposed and repurposed positions are geared towards effective support to the roll out of Test and Treat, the achievement of 90-90-90 as outlined in the Goal Statement above and strengthened technical and programmatic oversight. For additional details on staffing, please refer to the Annex E and the COP16 staffing database.

CDC proposes three new positions: 1) Public Health Analyst to help provide financial & fiduciary oversight of grantees. 2) Surveillance Specialist: to provide essential TA and capacity building to MISAU around HIV surveillance activities, including both national-level and clinical surveillance activities, 3) Deputy Branch Chief: to support Prevention Branch Chief in developing and formulating new prevention program and initiative, including VMMC, DREAMS, Key Population, GBV, and HTC. The incumbent will also serve as the senior public health specialist within the branch and participate in in external engagement and development of strategic direction for prevention portfolio. All but the Public Health Analyst will be filled by Locally Employed Staff. CDC staffing reflects five vacancies, four of which are Locally Employed (LE) staff and one is a Direct Hire

USAID staffing reflects 13 vacancies of which eight are LE and five are either U.S. Direct Hires or USPSCs. Four of these vacant positions are Non-PEPFAR funded positions which will allocate a percentage of their time to PEPFAR work. Three of these positions are partially PEPFAR-funded positions. Six of these vacant positions are positions fully funded by PEPFAR. All positions are intended for the same purpose as identified in COP15 with no repurposing or new hire requests. Hiring for these vacant positions, focused on programmatic and technical oversight, is in progress.

The current **DOD** vacancy for a HIV Care and Treatment Specialist will be filled before the end of this fiscal year. This is new position in COP16, previously approved via reprogramming in 2015.

State Department has two LE vacancies. The DREAMS Coordinator will support the implementation of DREAMS activities across agencies, engagement & coordination with external stakeholders and reporting to OGAC. The Senior PEPFAR Outreach and Communications Specialist is repurposed to a Data Manager who will focus on providing efficient support to the interagency team in meeting quarterly reporting requirements.

Peace Corps will fund 77 volunteers in COP16 who are placed with IP, health facilities or communities in scale-up districts, and will support activities that strengthen community-facility linkages.

Across all agencies, Host Country Nationals represent 75% of a total of 272 positions that support PEPFAR implementation. Agencies will dedicate a total of approximately XXX per quarter to support the implementation of SIMS.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• HTC • Care and Treatment (Tx), post-violence care • Retention and linkages – M2M and mentor mothers, GAACS, health educators, PHDP • TB- screening, diagnosis and Tx • PMTCT – C&T, B +, partners testing, EID • HRH- in service training, distance learning, accreditation • SC LMIS • PoC evaluation for Genexpert in pregnant and breastfeeding women at community level for VL,EID and TB • **Lab:** lab diagnostics & reagent resupply; equipment maintenance, integrated specimen referral, VL & drug resistance testing; in-service training & certification. EQA for rapid testing; laboratory information & results reporting systems • OVC – case management approach • Key & Priority Populations: Military, AGWY, MSM, FSW, PWID • VMMC • Condoms • PrEP, PEP, GBV • Blood banks – QA • **SI:** SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH	• Couples testing, • Pre-ART – some lab tests, cervical cancer screening and Tx, STIs, Kaposi, therapeutic feeding • FP/HIV integration • Infection control • TB/HIV – MDR ward renovations • OVC – village savings, vocational training, household economic strengthening • Stigma & discrimination community level activities • Lab: Laboratory QI implementation	
Sub-national level	• Supply Chain logistics, and operational support • Provincial support for in-service training, mgmt., supervision • Improved HCW deployment • LMIS, lab supply chain • Lab: Specimen referral system, in-service training & certification of lab staff in HIV and HIV-related testing, Laboratory information & results reporting systems	• Warehouse rentals • LMIS inventory management • Laboratory network support; lab pre-service training • Social worker/para social worker training	
National level	• **Supply Chain:** – LMIS, warehouse operations and quality management, Quantification & Supply planning, Lab supply chain, management; National product supply management. • LMIS, equipment & commodities, specimen referral, drug resistance	• Care and Tx National guidelines • Commodity security • LMIS; Training & mentorship to MISAU staff in lab logistics & tools for lab commodities quantification pipeline	

	testing, Laboratory information & results reporting systems **SI:** SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH **Surveillance:** ANC, VL and DR, AIS/DHS	analysis & warehouse management (MACS); SC: PELF implementation Pre-service training TA for HRH policy Drug quality control Warehouse rental Lab: EQA LMIS for lab supply chain management; Lab quality improvement program CS – PLHIV network capacity building Social protection advocacy/ policies Blood safety – national guidelines **SI**: IBBS, HIV mortality survey, VACS, combination prevention evaluation; strengthen systems at MISAU **HCF and Financial management**: Strategy development & implementation
HTS	• Focused HTC activities (PICT, VCT and index case testing) in epi burden districts • **RTKS** – procurement , supply, distribution • Quality improvement – HCW training, EQA • Reinforce linkages into Care and Tx • M&E processes including collection of sex/age disaggregated data	• **Demand creation**: - Training of HCW, replication of PHDP materials • Quality improvement for HTC including GBV prevention • Reproduction/dissemination of materials including job aids, provider guidance, and patient information
Care and Treatment	• Demand creation for care and treatment in scale-up districts • **Pre-ART Package,** Counseling, PHDP, WHO staging, CD4, CTX, screening for OIs, FP Integration, NACS, syphilis testing • **TB/HIV**: screening including of risk groups: people with diabetes , malnourished, heavy smokers , previous TB, with linkage to treatment, Tx, HIV testing of TB and of presumptive TB cases Contact tracing, IPT, Cough officers, IC, Health Educators, MDR-TB, specific programs addressing miners and prisoners • **ART**: Clinical Mentoring, Tx monitoring (CD4, VL) Warm line, Job aids, In-service training, POC diagnostics, Pre-ART counseling for same-day initiation (lay counselor), Pharmacovigilance Expand OSM; Test and treat KPs. • **Treatment support & retention**: Health Educators, Support Groups, GAACS, M2M, community ART distribution, Adherence counseling,	• **Pre-ART:** STIs, Hb, Cr, LFTs, Cervical CA, Kaposi Sarcoma; Therapeutic food, , TA for PRN, Messaging • **Nutrition:** nutrition education, therapeutic feeding, provincial/district supervision, QI, development of community service directories • **Integration of FP and HIV** - materials, training HWs and service provision • **TB/HIV:** Outreach services in high TB and HIV burden sites Renovations to MDR-TB wards, expansion of TB diagnosis (lab); lab technician training, referral systems expansion of x-ray diagnosis, support electronic TB register • **PMTCT** partner testing, disclosure • **Treatment support & retention** VSLG, Stigma reduction, Nutritional

	Tx literacy, referrals, condoms, MCP, disclosure, Teen Club/SAAJs, Adolescent transition to Adult Care • **Sex disaggregated data**	support
Prevention	**Key Populations** – CSW, MSM, PWID, prisoners • Reach-test-treat interventions • KP friendly clinics focusing on CSW and MSM • Medically assisted therapy for PWID (pending formal approval from MISAU) • Advocacy	
	Priority Populations - Military, adolescent girls & young women, miners • Reach-test-treat for miners	
	VMMC • MC procedures focusing on epi-burden districts with <80% VMMC saturation and age stratum 15-29 yrs • Demand creation activities • HIV testing and counseling • Condom use and safer sex education	
	Gender and Gender-Based Violence • Ensure availability of MISAU post-GBV services package at ART sites • Provision of PEP for post-rape care • Screen for GBV to determine effects on Tx & Adherence • Engage men in developing positive health seeking behaviors; communication strategies	• **Social protection** – advocacy for polices, harmful traditional practices,
	Other Prevention • **Condom** procurement, promotion and distribution • **PReP** (Pre-Exposure Prophylaxis): • **Occupational Post-exposure prophylaxis** • **Blood safety:** HIV quality assurance in blood banks	• **Stigma & discrimination** – HW training, community education (including KPs) & increased male involvement in health councils, mass media toolkit; • **STIs**: -update national guidelines and SOPs, adolescent SRH, Training of HWs • **Infection control** in health facilities through training in SOPs and supply of protective materials • **Blood safety**: Revision of national guidelines and rational use of blood components • **Household economic strengthening**
	Sex/Age disaggregated data	
OVC	• **Case Management:** Assessing child & family socio-economic status at Household level (across all areas: healthy, safe, stable, schooled) • Implementing special studies to identify gaps in programming impact	• **Case Management:** Mapping services within targeted communities and developing service directories • Supporting the development of national

	• **Healthy:** Promotion of EID and confirmatory HIV testing • Strengthen adherence assessment, counselling and support into routine OVC Home visitors work • Referral of suspected malnutrition, nutritional education at HH and community level • Facilitate uptake of and monitoring completion of referrals for Health, Food and Nutrition, TB/HIV, treatment and care services for all children and family members of index cases, SRH and FH services for ALHIV, including AYFS • **Safe:** Facilitating birth registration, succession planning • Positive Parenting focused on adult/child communication and protective and provider roles, HIV disclosure and child health • Support psychosocial health among children, their caregivers, teachers, through individual, home, group-based and relationship-based activities • Support community and national level child protection/ GBV prevention and response activities, including emergency food and shelter for abuse survivors • **Stable:** Facilitate establishment of savings groups plus (including financial literacy) • Support access to and uptake of social protection for all eligible according to GRM PSSB, PASD and PASP criteria • **Schooled:** Facilitate access to primary and secondary education through temporary and targeted support through support with uniforms, school fees, exam fees • Temporary school block grants to promote enrollment and progression • Early childhood development (ECD) for children under five with strong linkages with PMTCT and pediatrics • Long-term or open-ended school block grants or support for ECD centers, Positive parenting, • Economic strengthening • Sex disaggregated data	MIS • Training in strength's based case management for Community OVC Volunteers within PEPFAR catchment areas • Strengthening referral mechanisms and other systems for linking clinical, social and protection services • **Safe:** Strengthening government-managed case management systems to prevent and respond to child abuse and Support family placement and temporary permanency support for children • Strengthening community-based structures for mediation of child abuse and violence cases • Professional Development for social and para-social workers • M&E systems for National child protection/ social welfare efforts • **Stable:** Carry out market assessments to identify potential Income generating Activities (IGAs) with links to existing businesses / agricultural projects and markets/value chain development • Targeted food security for destitute families • Facilitate access to primary (and secondary education for girls) through long-term or open-ended subsidies • Zero-tolerance interventions to make classroom environments gender and HIV sensitive, and safe places for vulnerable children • Support community school councils
Program/system support	• Laboratory: Lab diagnostics & reagent resupply, equipment & maintenance, specimen referral, VL & drug resistance testing; in-service training. EQA program; lab supply chain coordination; laboratory information & results reporting systems; HIV Rapid Testing Quality Improvement Initiative • CSO - capacity building for Network for PLHIV	• Commodities: ARVs, RTKs, OI drugs, Lab reagents- VL, CD4 • Laboratory: Lab quality improvement program; Laboratory supply chain logistics & management strengthening of MISAU, Pre-service training for lab technicians; promote approval of national lab

	• Supply Chain: – LMIS , WH operations and quality management, Quantification & Supply planning, Lab SC, management • SI: SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH • Surveillance: ANC, VL and DR, AIS/DHS • HRH: In-service training	policy • Supply Chain –hardware inputs for LMIS; PELF implementation strategic management and design, commodity security, commodity importation • Support a phased transition of commodity management from SCMS to MISAU • Warehouse management. CMAM internal governance systems, drug quality • SI: IBBS, HIV mortality survey, VACS, combination prevention evaluation; improve systems at MISAU • HCF and Financial management: Strategy development & implementation • HRH: HRIS, pre-service training

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP16	Estimated Funding in COP17	# of IMs	Transition End date	Notes
No activities						
Totals						

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend

B.2 Resource Projections

Describe what inputs and methods were used to calculate required resources to sustain program activities in the coming implementation year. Describe data sources and adjustments made. Detail should be sufficient so an HQ reviewer can replicate the calculations.

APPENDIX C

Systems Investments for Section 6.0

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents and supplies, travel and transport, building rental and utilities will not be included

APPENDIX D: TEST & START PHASED IMPLEMENTATION

PHASE 1: PROVINCIAL CAPITALS (w/ Inclusion of Chokwe District)

Provisionally scheduled for August 2016

No.	Province	District	PLHIV
1	Niassa	Cidade de Lichinga	8,715
2	Cabo Delgado	Cidade de Pemba	19,155
3	Nampula	Cidade de Nampula	38,603
4	Zambézia	Cidade de Quelimane	46,070
5	Tete	Cidade de Tete	23,601
6	Manica	Cidade de Chimoio	40,296
7	Sofala	Cidade da Beira	76,701
8	Inhambane	Cidade de Maxixe	7,745
9	Gaza	Area Xai-Xai[1]	58,361
10	Maputo Provincia	Cidade de Matola	130,497
11	Maputo Cidade	Cidade de Maputo[2]	147,690
12	Gaza	Distrito de Chokwe[3]	32,493

1 - Area of Xai-Xai composed of City and Xai-Xai District

2 - Maputo City made up of all the municipalities of Maputo City

Number of PLHIV captured in Phase 1 of "Test and Start" Introduction	***629,927***
Phase 1 coverage of national PLHIV	***40%***
Phase 1 coverage of PLHIV in 29 "Test and Start" Districts	***66%***

PHASE 2: 8 DISTRICTS

Provisionally scheduled for Feb 2017

No.	Province	District	PLHIV
12	Maputo Provincia	Distrito de Manhiça	36,514
14	Gaza	Distrito de Bilene Macia	31,483
15	Zambézia	Distrito de Namacurra	28,932
16	Zambézia	Distrito de Mocuba	19,316
17	Zambézia	Distrito de Nicoadala	33,453
18	Sofala	Distrito de Dondo	20,767
19	Tete	Distrito de Moatize	12,856
20	Sofala	Distrito de Nhamatanda	11,778

Number of PLHIV captured in Phase 2 of "Test and Start" Introduction	***195,099***
Phase 2 coverage of national PLHIV	***12%***
Phase 2 coverage of PLHIV in 29 "Test and Start" Districts	***21%***

PHASE 3: 9 DISTRICTS

Provisionally scheduled for August 2017

No.	Province	District	PLHIV
21	Manica	Distrito de Manica	20,059
22	Cabo Delgado	Distrito de Mueda	16,245
23	Manica	Distrito de Gondola	25,798
24	Cabo Delgado	Distrito de Montepuez	9,450
25	Nampula	Cidade de Nacala-Porto	13,142
26	Inhambane	Distrito de Vilanculo	10,419
27	Inhambane	Distrito de Massinga	8,329
28	Niassa	Distrito de Cuamba	7,760
29	Tete	Distrito de Changara	11,124

Number of PLHIV captured in Phase 3 of "Test and Start" Introduction	***122,327***
Phase 3 coverage of national PLHIV	***8%***